

LEAVE REQUEST

Name of employee _____

Name of supervisor _____

Date of leave (specify each day and/or number of hours) _____

Type of leave (sick leave* - medical visit - compensating time - holiday)

**Sick leave of more than one day must be certified by MD's INPS certificate.*

Notes (explain compensating time) _____

Employee's signature _____

Supervisor's approval _____ Date _____

THIS FORM MUST BE RETURNED TO THE HUMAN RESOURCES OFFICE

For HR DIRECTOR use only.

Notes _____

Applied on _____ payroll
(month)

Date _____ Signature _____