

REQUEST FOR LEAVE

EMPLOYEE'S NAME _____ DATE _____

TYPE OF LEAVE: (CHECK ONE)

_____ ABSENCE: (PLEASE CHECK REASON FOR ABSENCE)

FROM _____ TO _____ TOTAL DAYS _____

- Illness – Personal Dentist/Doctor
- Illness – Family Bereavement (Please Indicate) Immediate Fam. Other
- Vacation Other (Explain) _____

_____ PROFESSIONAL LEAVE

FROM _____ TO _____ TOTAL DAYS _____

PURPOSE OF REQUEST _____

LOCATION: _____

_____ PERSONAL LEAVE (For Personal Leave Without Pay, see Below)

FROM _____ TO _____ TOTAL DAYS _____

Substitute Signature

Employee Signature

Date Approved

Date Approved

Date Disapproved

Date Disapproved

Principal's Signature

Superintendent Signature

REQUEST FOR PERSONAL LEAVE WITHOUT PAY

EMPLOYEE'S NAME _____ DATE _____

NO. OF DAYS REQUESTED _____ DATES REQUESTED _____

Employee Signature

Superintendent Signature

Date Approved

Date Disapproved