Leave Request

Form 1A

Name _____
Department _____
Title _____
Leave Beginning (MM/DD/YY) _____/____/_____ At _____
Leave Ending (MM/DD/YY) _____/____/_____ At _____ End Unknown _____

Leave Type	Leave Hours Requested	Time Accrued*	Balance
Vacation	_____	_____	_____
Sick**	_____	_____	_____
Military	_____	_____	_____
Civil	_____	_____	_____
Leave Without Pay	_____	_____	_____
Maternity	_____	_____	_____
Compensatory	_____	_____	_____
Holiday	_____	_____	_____

*Main office will input this information
**Prior approval is required for nonemergency medical treatment and care.

_____
Explanation

_____ _____
Employee Signature Date

_____ _____
Supervisor Signature Date

_____ _____
Superintendent Signature Date

Approved _____ Denied _____ Recorded _____
Prepare and submit two copies to office for input of time accrued. The original copy will be filed in the employee personnel file and the copy will go to the employee.

_____ _____
Substitute Employee Signature Date