

LEAVE REQUEST AND APPROVAL FORM

- **Discretionary Leave:** Submit this form for approval **PRIOR** to the requested absence from duty. Form must be submitted immediately upon return for all other leave.
- Absences of 3 or more consecutive days for personal or family illness must have a written statement from a health care practitioner attached.
- Leave requests will be granted and recorded in accordance with board policy DEC.

Name	Position	
Department/Campus		
Reason for Absence	Date(s) of Absence	Total Days Absent
<input type="checkbox"/> Personal illness or medical appointment Is illness or injury work-related? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Illness or medical appointment in family <i>Specify relationship:</i>		
<input type="checkbox"/> Death in family <i>Specify relationship:</i>		
<input type="checkbox"/> Personal business		
<input type="checkbox"/> Vacation (<i>only for 12 mo employees</i>)		
<input type="checkbox"/> Family and medical leave (including care for a newborn child, placement of a child, qualifying exigency, etc.)		
<input type="checkbox"/> Jury duty or subpoena (attach documents)		
<input type="checkbox"/> Assault leave		
<input type="checkbox"/> Prize Day		
Employee Signature	Date	
Principal/Supervisor Signature	Date	
Leave Status: <input type="checkbox"/> Approved <input type="checkbox"/> Disapproved		
For Office Use Only: Category and amount of leave recorded: <input type="checkbox"/> State personal leave ____ days <input type="checkbox"/> State sick leave ____ days <input type="checkbox"/> Local leave ____ days <input type="checkbox"/> Comp time ____ hours <input type="checkbox"/> Vacation ____ days <input type="checkbox"/> Prize ____ days		
Notice provided to employee: <input type="checkbox"/> FMLA <input type="checkbox"/> Workers' compensation election to use paid leave		

Complete form prior to taking leave, except sick. Sign form then forward to supervisor for approval. Turn completed form in to Business Office.