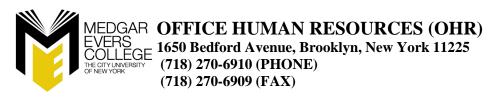


APPLICATION FOR LEAVE

For illness extended for more that 3 consect In case of protracted disability, a certificate in the medical certificate on the back of this was not obtained. Signature of Employee Date Chairperson's/Supervisor's Name	s form; otherw		
In case of protracted disability, a certificate in the medical certificate on the back of this was not obtained.			
In case of protracted disability, a certificate in the medical certificate on the back of this			
☐ Medical, dental, or optical treatment by _	Doctor's Name	e	
☐ Nature of illness which incapacitated me	for duty		
• I certify that this absence was due to:			
• Note – Annual Leave authorized in exwithout Pay.	xcess of that to	o your credit w	ill be charged to Leave
Number of Days Off:	or	Number of I	Hours Off:
p.m.			p.m.
a.m.			a.m.
BEGIN DATE (month, day, year and how	ur)	END DATE (1	nonth, day, year and hour)
TYPE OF LEAVE: □ Annual □ Sick			☐ Bereavement
DEI ARTWENT.			
DEPARTMENT:			
NAME: DEPARTMENT:			

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APPLICATION FOR LEAVE

CERTIFICATE OF PHYSICIAN OR PRACTITIONER

I certify that the person named below has been under my professional care.			
Name			
Address			
BEGIN DATE (month, day, year and hour)	END DATE (month, day, year an	d hour)	
a.m.		a.m.	
p.m.		p.m.	
Prognosis:			
Remarks:			
Expected Date of Return:			
Physician's Name (Please Print)	Signature of Physician Date	e	

06/14/2021 Page 2 of 2 Application for Leave must be submitted to the Office of Human Resources.