MEDGAR EVERS COLLEGE
THE CITY UNIVERSITY OF NEW YORK

OFFICE HUMAN RESOURCES (OHR)
1650 Bedford Avenue, Brooklyn, New York 11225
(718) 270-6910 (PHONE)
(718) 270-6909 (FAX)

APPLICATION FOR LEAVE

DATE: _____

NAME: _____

DEPARTMENT: Academic Affairs _____

TYPE OF LEAVE: ☐ **Annual** ☐ **Sick** ☐ **Unscheduled Holiday** ☐ **Bereavement**

BEGIN DATE (month, day, year and hour)	
	a.m.
	p.m.

END DATE (month, day, year and hour)	
	a.m.
	p.m.

Number of Days Off: _____ **or** **Number of Hours Off: _____**

- **Note – Annual Leave authorized in excess of that to your credit will be charged to Leave without Pay.**

- I certify that this absence was due to:

☐ Nature of illness which incapacitated me for duty _____

☐ Medical, dental, or optical treatment by _____
Doctor's Name

For illness extended for more that 3 consecutive work days, a physician's certificate must be presented. In case of protracted disability, a certificate must be presented each month. Request your doctor to fill in the medical certificate on the back of this form; otherwise, state under "Remarks" why the certificate was not obtained.

_____
Signature of Employee **Date**

_____
Chairperson's/Supervisor's Name **Signature** **Date**

_____
Appropriate Dean/Area Head Name **Signature** **Date**

Application for Leave must be submitted to the Office of Human Resources.

Reset Form Print Form

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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 and hour)**	
	a.m.		a.m.
	p.m.		p.m.

Number of Days: _____

_____

_____

Prognosis:

_____

_____

Remarks:

_____

_____

Expected Date of Return: _____

_____ _____

Physician's Name (Please Print) **Signature of Physician** **Date**

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