College of Agricultural, Consumer and Environmental Sciences

REQUEST FOR LEAVE

I hereby certify that my absence from work is due to the reasons listed below:

_____ _____
(Print name) (Signature)

_____ _____
(Location) (Date signed)

LEAVE IS REQUESTED FOR THE FOLLOWING DATE(S)

BEGINNING	ENDING	TOTAL
_____ Beginning date Time	_____ Ending date Time	_____ Total hours and type of leave (also check below)

❑ Annual ❑ Sick ❑ Medical ❑ Dental ❑ Optical

❑ Military/Jury duty (attach backup documents)

❑ Compassionate (Death in the immediate family. See *Handbook* for details.)

Relationship _____

Doctor note or certification below is REQUIRED for sick leave absences exceeding 3 consecutive days.

I certify that _____ was under my professional care from (date) _____ to (date) _____ , inclusive.

Signed: Dr. _____

Address: _____

Date _____ _____

APPROVED

_____ _____
(Supervisor signature) (Date)

_____ _____
(Supervisor signature) (Date)