LEAVE REQUEST

Employee Name:

Department:

Sick Date Hours Absent

Self (Doctor's Certificate - mandatory after 3 days sick)
Attached : Yes No

Family Relationship to Employee:

Doctor/Dentist Date Hours Absent:

Bereavement Date Relationship to Employee:

PRE-AUTHORIZED TIME OFF

Annual Vacation	Start	Return	Days
Time Off in Lieu of Overtime	Start	Return	Days
Management Time	Start	Return	Hours

Moving Date Please indicate new address & phone # below

Education/Conference/Seminar Start Return

Other: Please give details in space provided below.

Comments:

Note: I authorize the ***sportalliance*** to deduct any unearned vacation I have taken from my final salary payment.

Employee Signature Date

Authorizing Signature (Supervisor) Authorizing Signature (Department Head)