



APPLICATION FOR LEAVE

DIRECTIONS: In order to request leave, an employee shall complete this form and forward it to his or her supervisor.

EMPLOYEE'S SECTION (PART A)			
Name:		Date of Request:	
Department:		Division:	
Leave Beginning Date:		Time:	
Leave Ending Date:		Time:	
Total Hours Requested:			

LEAVE CATEGORIES

Check all that apply and fill in hours requested. All leave must be taken in minimum of fifteen minute increments.

<input type="checkbox"/> Administrative Leave: ____ hour(s) <input type="checkbox"/> Bereavement (Immediate Family): ____ hour(s) <input type="checkbox"/> Civil: ____ hour(s) <input type="checkbox"/> Compensatory: ____ hour(s) <input type="checkbox"/> Conference/Convention: ____ hour(s) <input type="checkbox"/> Educational: ____ hour(s) <input type="checkbox"/> Fire Holiday: ____ hour(s) <input type="checkbox"/> Holiday Floating (taken in full 8 hours): ____ hour(s) <input type="checkbox"/> Holiday Leave Credit: ____ hour(s) <input type="checkbox"/> Injury: ____ hour(s)	<input type="checkbox"/> LWOP (Approved): ____ hour(s) <input type="checkbox"/> Military with Pay: ____ hour(s) <input type="checkbox"/> Military without Pay: ____ hour(s) <input type="checkbox"/> Police Holiday: ____ hour(s) <input type="checkbox"/> Sick (Immediate Family): ____ hour(s) <input type="checkbox"/> Sick (Self): ____ hour(s) <input type="checkbox"/> Vacation: ____ hour(s) OTHER LEAVE (NOT LISTED) <input type="checkbox"/> Other Leave (specify) : ____ hour(s)
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FMLA LEAVE CATEGORIES (Applies to FMLA and Paid Parental Leave only)

<input type="checkbox"/> Compensatory Time: ____ hour(s) <input type="checkbox"/> Military Caregiver LWOP: ____ hour(s) <input type="checkbox"/> Military Caregiver Sick: ____ hour(s) <input type="checkbox"/> Military Caregiver Vacation: ____ hour(s) <input type="checkbox"/> Military Caregiver Compensatory Time: ____ hour(s) <input type="checkbox"/> Military Caregiver Holiday: ____ hour(s) <input type="checkbox"/> Military Caregiver Veteran LWOP: ____ hour(s) <input type="checkbox"/> Military Caregiver Veteran Sick: ____ hour(s) <input type="checkbox"/> Military Caregiver Veteran Vacation: ____ hour(s) <input type="checkbox"/> Military Caregiver Veteran Compensatory Time: ____ hour(s) <input type="checkbox"/> Military Caregiver Veteran Holiday: ____ hour(s) <input type="checkbox"/> Military Qualifying Exigency LWOP: ____ hour(s) <input type="checkbox"/> Military Qualify Exigency Sick: ____ hour(s)	<input type="checkbox"/> Military Qualify Exigency Vacation: ____ hour(s) <input type="checkbox"/> Military Qualify Exigency Compensatory Time: ____ hour(s) <input type="checkbox"/> Military Qualify Exigency Holiday: ____ hour(s) <input type="checkbox"/> Leave without Pay (LWOP): ____ hour(s) <input type="checkbox"/> Paid Adoption/Foster Care Placement: ____ hour(s) <input type="checkbox"/> Paid Bonding: ____ hour(s) <input type="checkbox"/> Paid Care of Sick Parent: ____ hour(s) <input type="checkbox"/> Paid Maternity: ____ hour(s) <input type="checkbox"/> Qualifying Exigency – Military Family: ____ hour(s) <input type="checkbox"/> Sick: ____ hour(s) <input type="checkbox"/> Vacation: ____ hour(s) OTHER FMLA LEAVE (NOT LISTED) <input type="checkbox"/> Other FMLA Leave (specify) : ____ hour(s)
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I certify that the information in Part A is correct and true.

Signature of Employee: _____

Date: _____

REVIEWER'S SECTION (PART B)

Is this leave for Family and Medical Leave Act (FMLA) purpose?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
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If 'Yes', indicate the amount of each leave type to be applied towards FMLA requirements.

Leave Type:		Hours:	
Leave Type:		Hours:	

Approved: <input type="checkbox"/>		Disapproved: <input type="checkbox"/>	
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Comments:	(250 character limit)
(If 'disapproved' explain why.):	

I certified that I have reviewed this request for FMLA compliance.

Authorizing Signature: _____

Date: _____