

PROFESSIONAL EMPLOYEES LEAVE REQUEST/APPROVAL FORM*

**A & P, DEPARTMENT CHAIRS, ACADEMIC SUPPORT PROFESSIONALS
AND TEMPORARY OR CONTRACTED PROFESSIONALS**

Name (print) _____

Department _____

Date _____

Signature _____

REQUESTING VACATION LEAVE

From: _____

Through: _____

Total Days: _____

REPORTING SICK LEAVE

From: _____

Through: _____

Total Days: _____

SICK LEAVE TYPE:

Self

Family

Parental

REPORTING FUNERAL LEAVE

From: _____

Through: _____

Total Days: _____

**REPORTING LEAVE FOR COURT
REQUIRED SERVICE**

From: _____

Through: _____

Total Days: _____

REPORTING MILITARY LEAVE

From: _____

Through: _____

Total Days: _____

Signature _____

Date _____

**NOTE: MINIMUM INCREMENT FOR SICK LEAVE AND ALL OTHER LEAVE USAGE IS 1/2 DAY.
PLEASE SUBMIT FORM AS PROMPTLY AS POSSIBLE.**

* OTHER THAN FACULTY

DISTRIBUTION — Supervisor