Department of Medicine
EMPLOYEE - REQUEST FOR LEAVE
For ENDO, ID and RHEUM ONLY

Is this a planned leave request > 2 weeks? ___________________

Is this an emergency leave request? ________________________

If yes, explain ____

Is this an unplanned leave request? ________________________

If yes, explain ____

Have you completed your provisional period? _________________

Name: ________________________________

Date Submitted: ________________________

Type of Leave:

_____ **Annual Leave**

_____ **Sick Leave: The amount of sick leave authorized must not exceed two (2) hours for regular appointments.**
Provide brief description of this leave request: i.e. Appointment, Bereavement etc.
____

_____ **Other (Specify) (UH) Unscheduled Holiday, (JD) Jury Duty, (LW) Leave Without Pay, (FMLA) Family Medical Leave – prior approval / medical certification**

Amount of Leave to be Taken: ___________

*** My Available Leave is: Annual Leave _______ Sick Leave_______ UH______**

* Must fill in all three types of leave hours above and submit copy of leave balance from MyMCG

Leave date(s) and time:

From: (date) __________________________ **(time)** __________________

To: (date) ___________________________ __ **(time)** ____________________

Person responsible during your absence: ___________________________________

Will all deadlines/critical work duties be completed prior to your absence? ______

____

(Employee) **(Date)**

This time is approved based on the condition that you have the adequate leave available. If something occurs between now and this requested time off and you do not have this leave available to take on this date(s), we will need to meet and discuss whether this time will still be granted.

____

(Business/Program Manager or Designee) **(Date)**

____

Reviewed by: Dept. Manager/Director **(Date)**