



Department of Medicine
EMPLOYEE - REQUEST FOR LEAVE

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 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 Manager or Designee)

(Date)