Department of Family & Community Medicine

Prior Approval

Annual Leave, Planned Sick Leave, and Professional Leave

This Form is required for all staff

STAFF ONLY

Name: ______________________ **Date Requested:** ______________

ANNUAL LEAVE (Refer to policy #3400)

Date (s)	Total Hours Per Day	Total Hrs.
	Total Hours Requested:	

SICK LEAVE (Refer to policy #3410)

Date (s)	Total Hours Per Day	Total Hrs.
	Total Hours Requested:	

TOTAL HOURS: ______

PROFESSIONAL LEAVE

Purpose of Professional Leave:

Account number is required when professional leave is requested for a compensated activity.

Date (s)	Total Hours Per Day	Total Hrs.
	Total Hours Requested:	

Who will be covering (if needed) for you in your absence: ______________________

Supervisor's Name & Title | Supervisor's Signature | Date

Note: All paid leave requires prior approval by your supervisor. *Please submit this complete form to: Amy Herrera (Exempt Staff) or Norma Dye (Non-Exempt Staff).*