Time Off Application Form

Employee Name: _____ **Date:** _____

Office/Department: _____

Supervisor Name: _____

Time off: (check one)

☐ **Is for a future date** ☐ **Is for a past date**

Start Date	End Date	Total Days Missed	Total Hours Missed

I hereby request:

- ☐ Personal/Annual/Vacation Leave
- ☐ Sick Leave
- ☐ Leave without pay
- ☐ Compensatory Time
- ☐ Other: _____

Employee/Supervisor Comments

Approved: ___ **Disapproved:** ___ **Supervisor Signature:** _____ **Date:** _____

If required by your office, please have your physician or practitioner complete the section below.

Certification of Physician

I certify that the employee named was under my professional care for the period indicated above and as a result of their condition made reporting to work inadvisable.

Physician Signature: _____ Date: _____