BISHOP STATE COMMUNITY COLLEGE

REQUEST FOR LEAVE FORM

_____ _____

EMPLOYEE'S NAME (PLEASE PRINT) DATE

TYPE OF LEAVE REQUESTED

_____ SICK LEAVE

_____ ANNUAL LEAVE

_____ PERSONAL LEAVE

START DATE: _____ END DATE: _____

AMOUNT OF LEAVE REQUESTED

DAYS(S) _____ HOURS(S) _____ MINUTES _____

PLEASE INDICATE THE RANGE OF TIME REQUESTING HOURS & MINUTES (i.e. 2:30-3:45pm)

_____

EMPLOYEE'S SIGNATURE

_____

SUPERVISOR'S SIGNATURE

_____

APPROVER 2 SIGNATURE (IF APPLICABLE)

FOR USE OF PERSONNEL ONLY

DATE ENTERED: _____

ENTERED BY: _____