LEAVE WITHOUT PAY REQUEST FORM

Name: _____

Position: _____

Start Date: _____

Scheduled return to work date: _____

Reason for request:

Do you want to use your accrued leave? _____ (Yes or No)

Annual Leave	_____ Days	_____ Hours
Sick Leave	_____ Days	_____ Hours
Compensatory Time	_____ Days	_____ Hours

If eligible, do you want to maintain your Health/Dental benefits? _____ (Yes or No)

If eligible, do you want to contribute to your retirement? _____ (Yes or No)

Employee Signature: _____ Date: _____

Supervisor Recommendation: ☐ Approve ☐ Disapprove

Signature: _____ Date: _____

Department Head/Program Manager Recommendation: ☐ Approve ☐ Disapprove

Signature: _____ Date: _____

Chief of Staff for State Operations ☐ Approved ☐ Disapproved

Signature: _____ Date: _____

NOTE: Attach all applicable documentation to your request (i.e., military orders, doctor's statements, etc.)