

University of Arkansas at Monticello

REQUEST FOR LEAVE

Date _____

With the exception of sick leave, this form must be approved before the leave commences. A Certification of Illness Form must be furnished for five or more consecutive days of sick leave.

I _____ request approval of leave
Name in full (Type or Print)

from _____ m. on _____ 20_____

to _____ m. on _____ 20_____ .

I certify that I have enough leave accrued to cover this request.

TYPE OF LEAVE

NUMBER OF HOURS

Vacation

Sick –Employee

–Family

Military

Jury or Witness Duty

Leave Without Pay

Other

Employee ID#

Signature of Employee

Signature of Supervisor

Explanation of "Other" and/or general comments: _____
