

▲ Name (please print) _____

▲ Work Location _____

Type of leave requested:

- Personal Business (Specify Reason: _____)
- Sick Leave (Personal Illness)
- Family Illness (Relationship: _____)
- Sick Leave (for Family Illness once Family Illness Leave is exhausted – maximum of 5 days)
- Bereavement (Relationship: _____)
- Religious
- Jury Duty (Attach Summons)
- Civil Service Examination (Attach Notice)
- Medical/Dental Appointment for Employee (Charged to Sick Leave)
- Professional Visit
- Vacation
- Leave Without Pay (Specify Reason: _____)
- Floating Holiday
- Breast/Prostate Cancer Screening (Submit **Verification of Paid Leave for Breast/Prostate Cancer Screening**)
- Other (Specify Reason: _____)

Leave request is: with pay without pay

Date(s) of leave (indicate if half day and if a.m. or p.m.):

▲ Employee Signature _____

▲ Date _____

▲ Supervisor Approval _____

▲ Date _____

▲ Director, Personnel & Labor Relations*

▲ Date _____

* Required for Personal Business Leave Requests for OCMBFT unit employees only