|  |  |  |
| --- | --- | --- |
|  |  |  |
| Employee Name (Print): |       |  |
| Division/Office: |       | Position Title: |       |  |
| Date Personal/Medical Emergency Began: |       | Anticipated Ending Date: |       |  |
|  |  |  |

LEAVE Request for:

[ ]  Annual Leave                   :

[ ]  Sick Leave                   :

(Code in Hours and Quarter Hours)

*Note: If leave is for a personal emergency, an employees’ sick leave usage during the course of his/her employment with the State may be considered during the review of this request.*

Effective Beginning       /       /       Ending       /       /

Duration of request cannot exceed 30 working days.

Reason for Request: Give a brief description of the nature, severity and anticipated duration of the circumstances that have generated this request. Include any pertinent facts and/or documentation that support this request. Attach additional documents as necessary.

I understand and agree that when the above-referenced personal/medical emergency or my employment with the Department of Administration (Admin) terminates any transferred annual or sick leave remaining to my credit must be restored to the appropriate leave transfer pool account. In addition, I agree and understand that I must continuously report the status of my personal/medical emergency to the Office of Administrative Services –Human Resources.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date |  |
| Manager/Supervisor Review: |  |
| Office/Division Director Review: |  |
| Executive Director Approval: |  |
| Human Resources Use Only: |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | hours approved from Annual leave or Sick leave (circle one) |  | Leave Pool or Specific Individual Donation (circle one) |