

COSHOCTON COUNTY
REQUEST FOR LEAVE

EMPLOYEE NAME: _____

JOB TITLE: _____

Request leave from: _____ to: _____

TYPE OF LEAVE REQUESTED:

Sick Leave Reason for leave: _____

Family Illness/Death Relationship to you: _____

Injury Were you injured at work: Yes No

Vacation

Personal Day

Court Leave

Military Leave Paid Unpaid

Educational/Volunteer

Compensatory Time

Other _____

HOURS REQUESTED:

Sick Leave _____

Family Illness/Death _____

Injury _____

Vacation _____

Personal Day _____

Court Leave _____

Military Leave _____

Educational/Volunteer _____

Compensatory _____

Other _____

TOTAL _____

If medical attention was required for an illness or injury that extended beyond three (3) days, you must attach the Medical Practitioner's statement stating nature of illness.

EMPLOYEE'S SIGNATURE

DATE

ADMINISTRATIVE USE ONLY

Recommended

Approved

Not Recommended

Disapproved

SUPERVISOR'S SIGNATURE

DATE

SIGNATURE

DATE