EMPLOYEE LEAVE REQUEST

Instruction: Please complete all applicable items

<table>
<thead>
<tr>
<th>Name: (Last, First)</th>
<th>Shift (Hotel Staff Only):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Requested Leave Date(s)</th>
<th>Return Date</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>Date(s)</td>
<td>Month</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I understand that this request is subject to approval by my supervisor. If you check more than one box or check box marked other, explain under Remarks.

- [ ] Vacation Leave (Vacation leave requested should not exceed the available amount for use during the year)
- [ ] Sick Leave (please complete reverse side of form if sick leave exceeds more than 3 days)
- [ ] Leave Without Pay
- [ ] Other (for example, Religious, Bereavement, Jury Duty, Military, Parental, etc.)

Remarks:

Employee’s Signature: Date:

Supervisor’s Action

- [ ] Approved
- [ ] Disapproved (Give reason. If Vacation Leave, initiate action to reschedule)

Reason/Comments:

Supervisor’s Signature: Date:

Revised 11/20/2019
EMPLOYEE: If you are applying for sick leave, complete sections 1-3 and check the appropriate item. A doctor’s certification may be required for absence in excess of 3 days. In this case, please have your physician complete the Certificate section below. Falsification of information in this portion of the form may be grounds for disciplinary action, including dismissal.

1. I was incapacitated for duty by:
   _____ Sickness  
   _____ Off-the-Job Injury
   _____ On-The-Job-Injury  
   _____ Pregnancy and Confinement

2. I was required to care for a member of my family with a serious illness. Give names and relationship of family member and nature of illness.
   Family Member Name: ____________________  Relationship: ____________________
   Did Physician order care?  ☐ Yes ☐ No  
   Physician’s Name: ____________________

3. I will be undergoing medical, dental, or optical examination or treatment.

   __________________________________________

   CERTIFICATION OF PHYSICIAN OR PRACTITIONER

   Employee’s Name: ____________________
   Period under Professional Care (indicate mm/dd/yy)  From: ____________ To: ____________
   Remarks and/or Special Instructions:
   __________________________________________
   __________________________________________

   I certify that the employee named was under my professional care for the period indicated above, and that the employee’s condition during this period made reporting to work inadvisable.

   Signature of Physician or Practitioner  Date (mm/dd/yy)
   ________________________________  ________________________