Leave Request Form

Human Resources
203 University Hall
3640 Colonel Glenn Hwy.
Dayton, OH 45435-0001
Tel: (937) 775-2120 Fax: (937) 775-3040

Wright Way policy provides that this form be completed for all leave requests. *For all leaves that are foreseeable in nature* (i.e. doctor appointment, scheduled surgery, maternity, vacation, compensatory time, etc.), this form must be completed and submitted in advance. *For sick leave requests that are not foreseeable* (i.e. sudden illness), this form must be submitted on the day of return from sick leave. Complete this electronic form for all leave requests. Print and sign the form, and provide it to the person who approves your leave. Keep a copy for your records.

Complete, print, sign and submit this form to your supervisor for approval.

UID: | Employee Name: | College/Dept:

I hereby apply for ____ **hours of:**

Check All That Apply

- ☐ **Sick Leave** (Provide reason below)

Sick Leave Reason:

- ☐ **Vacation** – Must be pre-approved
- ☐ **Parental Leave** – If you have no approved FMLA claim on file, contact Human Resources immediately.
- ☐ **Compensatory Time** – (Classified employees only)
- ☐ **Unpaid Leave (Must be pre-approved** – *for this leave type, this form with supporting documentation and necessary signatures must be forwarded through the department administrator to Human Resources for final approval)*

- ☐ **FMLA** *(1. Check the appropriate paid leave category [sick, vacation or parental] or check Unpaid Leave if the FMLA leave will be unpaid. 2.* ***If you have no approved FMLA claim on file, contact Human Resources immediately.*** *3. This form with the necessary signatures and supporting documentation must be forwarded to Human Resources for final approval)*
- ☐ **Other Leave Type (*i.e. Military Leave, Personal Leave, Administrative Leave, etc.*—***for these types, this form with supporting documentation and necessary signatures must be forwarded to Human Resources for final approval)

Other Leave Type
and Reason:

Leave Begin date: Leave Begin time (if applicable):

Leave End date: Leave End time (if applicable):

My physician expects my Return to work date to be:

I understand that it is my responsibility to monitor my leave balances, and verify that any paid time requested above has been accrued and is available for my use.

_____ _____
Employee Signature Date

_____ _____
Approver Signature Date

_____ _____
Dean, Director or Department Head Signature (if applicable) Date

_____ _____
Appointing Authority Signature (if applicable) Date