



ASA INSTITUTE

LEAVE REQUEST FORM

Employee's Name	Employee's Number	Request Date:
Job Title:	Department:	

Reason for Leave:

- | | |
|--|---|
| <input type="checkbox"/> Illness | <input type="checkbox"/> Jury Duty |
| <input type="checkbox"/> Personal Time | <input type="checkbox"/> Family Illness (name): _____ |
| <input type="checkbox"/> Vacation:
(Years of Employment: _____) | <input type="checkbox"/> Family Death (relation): _____ |
| | <input type="checkbox"/> Other (explain) : _____ |

Leave Requested :

FROM
Date: ___/___/___ Time: _____ a.m. p.m. Total number of hours requested: _____

RETURN
Date: ___/___/___ Time: _____ a.m. p.m. Total number of days requested: _____

Regular Work Shift: _____

Employee Signature: _____ Date: ___/___/___

Human Resources Verification

Total _____ Vacation Days available as of ___/___/_____.
Verified by _____

Request Approval

This leave to be approved: With Pay Without Pay

Approved By: _____ Title: _____

Signature: _____ Date: ___/___/___