LEAVE WITHOUT PAY REQUEST FORM

Name: _____

Position: _____

Start Date: _____

Scheduled return to work date: _____

Reason for request:

Do you want to use your accrued leave? _____ (Yes or No)

Annual Leave	_____ Days	_____ Hours
Sick Leave	_____ Days	_____ Hours
Compensatory Time	_____ Days	_____ Hours

If eligible, do you want to maintain your Health/Dental benefits? _____ (Yes or No)

If eligible, do you want to contribute to your retirement? _____ (Yes or No)

Employee Signature/Date: _____

Supervisor	Recommendation: Approve / Disapprove
	Signature/Date_____
Department Head/Program Manager	Recommendation: Approve / Disapprove
	Signature/Date_____
Chief of Staff for State Operations	Approved / Disapproved
	Signature/Date_____

NOTE: Attach all applicable documentation to your request (i.e., military orders, doctor's statements, etc.)