UCF College *Of* Medicine
LEAVE REQUEST FORM

Requestor / Employee: ______________________________ **Date submitted:** ____________

Date(s): _______________________________**Time(s):**_________________________________

Total days/hours off: ____

Reason for request: ____

Type of leave to be used: ☐ **Annual** ☐ **Sick** ☐ **Other** _________________ ☐ **Attachments**

☐ **I confirm that leave does not interfere with existing teaching, committee/service, or clinic responsibilities.**

Signature: ____ **Date:** ________________

Back-up designated: _____________________________________ **Back-up initials:**______

Employee Signature: _____________________________________ **Date:**________________

Supervisor Signature:_____________________________________ **Date:** _______________

Original with time sheet to payroll processor, retain a copy for your own files.

1/21/15