Your Hospital's Logo Here

REQUEST FOR APPROVED EMERGENCY COVERAGE, ABSENCE OR LEAVE

Employees must complete this form for all absences. Failure to complete it may result in the absences being charged to LEAVE WITHOUT PAY. Separate along dotted line below. *(Supervisor receives top copy / Employee receives bottom copy).*

NAME:	DATE:
JOB TITLE:	SSN: - -
IMMEDIATE SUPERVISOR:	EMERGENCY EMPLOYEE PHONE #:

I am requesting approval absence / leave or payment for emergency coverage period:

From DATE:	From TIME: (Military Time)	To DATE:	To TIME: (Military Time)

. . . For a total of ___________ working days and ___________ working hours. Charge this LEAVE TIME to:

- ☐ Paid Time Off: ________ Planned
- ☐ Paid Time Off: ________ Unplanned (Call-Ins)
- ☐ Administrative / Workshop
- ☐ Leave Without Pay (LWOP)
- ☐ Jury Duty
- ☐ Bereavement
- ☐ Holiday

Supervisor Copy

☐ ** CHECK IF THIS IS AN ABSENCE UNDER THE "FAMILY and MEDICAL LEAVE ACT"

If SHORT NOTICE Request (≤ 2 weeks), I have arranged for my shift coverage by:	NAME:	
Staff Member providing coverage:	SIGNATURE:	
Requestor:	SIGNATURE:	
Approving Supervisor:	INITIALS:	DATE:

TO: Employee ______________________________ Your request for leave from:

From DATE:	From TIME: (Military Time)	To DATE:	To TIME: (Military Time)

. . . has been:

☐ **APPROVED:** ________ **Planned Absence**

☐ **DISAPPROVED, due to:**

- ☐ Inadequate Coverage
- ☐ Other: ______________________________

Supervisor / Director SIGNATURE:	DATE:

NOTE: Employee MUST obtain / retain bottom portion to verify leave status or emergency coverage.

** FMLA Designation: This is notification that the above absence is designated as leave under the DC or Federal Family and Medical Leave Act: ___YES ___NO. If "YES", make an appointment to discuss with your Supervisor or Human Resources.

Employee Copy