LEECH LAKE TRIBAL COUNCIL

EMPLOYEE REQUEST FOR LEAVE **AUTHORIZATION FORM**

Name ______________________________ Division/Business ______________________________

Type/Purpose of Leave: ____ Personal ____ Bereavement ____ Leave w/o Pay ____ Short Term Medical Disability
____ FMLA ____ Military Duty ____ Jury Duty ____Educational ____ Ricing

Number of hours requested? _______

From: ______________________________ To: ______________________________
Date and time Date and time

***MEDICAL VERIFICATION MAY BE REQUIRED FOR ANY LEAVE FOR ILLNESS/MEDICAL REASON.**
(Attach required medical statements)

______________________________ ______________________________
Employee Signature Date Submitted / Applied

SUPERVISOR ACTION

_____ Approved _____ Denied: Reason ______________________________

______________________________ ______________________________
Supervisor's Signature Date Signed

Mandatory copies to: ☐ Division Director ☐ Employee ☐ Payroll