



Mississippi Band of Choctaw Indians

Application for Leave

Program _____

Date _____

Employee Name _____

Position Title _____

LEAVE DESIGNATION:

PERIOD OF LEAVE:

I request _____ or _____ of leave commencing _____
of Days # of Hours Time Month Day Year
and ending _____
Time Month Day Year

PAID LEAVE:

Request leave to be charged to: (Specify number of hours in each category)

_____ Annual _____ Civil* _____ Military* _____ Administrative Leave*
_____ Sick

Please Specify: Self Family*
 Illness/injury
 Medical Appointment

Bereavement Leave (Leave not to exceed 2 days)
Relationship* _____

UNPAID LEAVE: Medical* Personal*

Is this leave FMLA leave? If so, check box *
Is this leave related to a work injury? If so, check box *

Any item followed by an () requires appropriate documentation. I understand that approval of this request is contingent upon the availability of adequate leave balances. Falsification of this Application for leave or of the supporting documentation is grounds for disciplinary action, up to and including dismissal.

Employee Signature: _____ Date _____

Person responsible in my absence _____ Phone #: _____

In an emergency, I may be reached at: Phone # _____ E-mail: _____

Supervisor Signature: _____ Date _____
 Approved Disapproved # of Hours _____ Charge to: _____

Department Head (if necessary): _____ Date _____
 Approved Disapproved # of Hours _____ Charge to: _____

Tribal Chief (if necessary): _____ Date _____
 Approved Disapproved # of Hours _____ Charge to: _____

Comments: