



VOLUNTARY LEAVE TRANSFER PROGRAM
*****Leave Request*****

Employee: _____ Date: _____
Job Title: _____ Program/Dept: _____

Submit this request form to your supervisor at least 30 days before the leave is to commence, when practicable. The employer reserves the right to deny or postpone leave for failure to give appropriate notice.

A COPY OF YOUR LEAVE BALANCE FROM TIMEFORCE AND DOCTOR'S CERTIFICATE MUST BE ATTACHED. Deadline for submission is Friday (after payday) at 4:00 p.m. No exceptions.

REASONS FOR REQUESTING LEAVE:

I am requesting leave for the following reasons:

I. **Medical Emergency-** A serious medical condition of an employee or family member that is unlikely to require the absence from duty for a prolonged period. An employee may not receive more than 200 hours per fiscal year.

Personal serious health condition of employee (reason): _____

Serious health condition and/or death of a member of the immediate family- (state name and reason): _____

Birth of a Child expected delivery date is or scheduled date of adoption/placement: _____

II. **Life Threatening Condition-** An employee or whose immediate family member has been diagnosed with a **life-threatening condition the treatment for which is expected to exceed twelve (12) weeks as verified by a physician**, may receive up to an additional 280 hours of accrued leave per fiscal year from a **near relative**.

DATES OF LEAVE REQUESTED/EMPLOYEE STATEMENT:

I request leave from ___/___/___ to ___/___/___ . Total number of days/hours of leave that I am requesting is _____ . I agree to return to work on _____

If circumstances change such that I will not be able to return to work on that date, I agree to inform my supervisor by submitting a notice.

Signature of Employee: _____ Date: _____

Signature of Supervisor/Title: _____ Date _____

() Approved () Disapproved

TO BE COMPLETED BY HUMAN RESOURCES

Leave is _____ Approved _____ Denied for the following reason(s): _____

Request approved/denied by: _____ Date: _____

Human Resources Designee

Total number of hours charged to sick: _____

If Life Threatening Condition: _____ Date: _____

Human Resources Director

Total number of hours charged to sick: _____

c: Payroll
Timekeeper
Employee Copy
DOS Payroll Clerk (if applicant is employed by Choctaw Tribal Schools)