# REQUEST FOR LEAVE OF ABSENCE/VACATION (WITH PAY OR WITHOUT PAY)

*Please complete and submit to your direct supervisor. Where forms are incomplete, not returned or do not have required documentation attached (e.g. medical note), payment may be delayed at the discretion of the hospital.*

## EMPLOYEE INFORMATION

| | | | |
|---|---|---|---|
| **NAME:** | First | Last | Employee ID # |
| **DEPARTMENT:** | | **POSITION:** | |

## LEAVE OF ABSENCE / VACATION INFORMATION

| | |
|---|---|
| ☐ Banked Time Taken | ☐ Personal Leave *(Unpaid)* |
| ☐ Stat Time Taken | ☐ Bereavement *(Please note relation)*: |
| ☐ Vacation Time Taken | ☐ Maternity/Parental Leave |
| ☐ Sick Time Taken | ☐ Other Leave *(Please note reason)*: |

| **DATES:** One or Continuous Time | From: (dd/mmm/yyyy) | To: (dd/mmm/yyyy) | Total: (Days/Hours) | **DATES:** Multiple Dates | From: (dd/mm/yyyy)<br>From:<br>From: | To: (dd/mm/yyyy)<br>To:<br>To: |
|---|---|---|---|---|---|---|

☐ Medical Note Attached *(Required for absences of 3 consecutive shifts or more due to medical reasons)*

☐ ***Follow up discussion with Manager Next Business day (For Clinical area staff reporting to VP of Nursing)***

| | | | |
|---|---|---|---|
| EMPLOYEE SIGNATURE: | | DATE: | |

## *FOR OFFICE USE ONLY:*

### *DIRECT MANAGER/SUPERVISOR*

| | | | |
|---|---|---|---|
| **DATE RECEIVED:** | dd/mm/yyyy | **DATE APPROVED:** | dd/mm/yyyy |

**LEAVE APPROVED:** ☐ YES ☐ NO If NO, specify reason:

| | | |
|---|---|---|
| **MANAGERS SIGNATURE:** | | **Please Print** |

### *OCCUPATIONAL HEALTH*

**MEDICAL RECEIVED:** ☐ YES ☐ NO

| | | | |
|---|---|---|---|
| **DATE RECEIVED:** | dd/mm/yyyy | **DATE REVIEWED:** | dd/mm/yyyy |

| | | |
|---|---|---|
| **OCC HEALTH SIGNATURE:** | | **Please Print** |

### *PAYROLL*

| | | |
|---|---|---|
| CHANGES COMPLETE | ☐ QHR<br>☐ POSTED SCHEDULE | **Payroll Initials:** |

**Comment:**