

EMPLOYEE LEAVE REQUEST FORM
(Fax requests to 306-825-3991 Lloydminster Office)

Employee Name: _____ Employee Signature: _____

Position: Teacher Location: _____
(Name of School, Office)

Principal/Supervisor Signature (Signature verifies that the employee's immediate supervisor is aware of the request and the circumstances related to the request)

Please complete this section if you are requesting COMPASSIONATE LEAVE

_____ # DAYS REQUESTED WITH PAY _____ # DAYS REQUESTED WITHOUT PAY

Name of Family Member: _____ Relationship to Employee: _____

Date(s): _____ Reason for Compassionate Leave: _____

(Please cite applicable section of LINC or CUPE Agreement)

Please complete this section if you are requesting a leave OTHER THAN COMPASSIONATE

_____ # DAYS REQUESTED WITH PAY _____ # DAYS REQUESTED WITHOUT PAY

Date(s): _____

Description of Circumstances: _____
(Please cite applicable section of LINC or CUPE Agreement)

To be completed by the Superintendent of Human Resources

_____ # Days Granted With Pay _____ # Days Granted Without Pay _____ Request Denied

Comments: _____

Date: _____ Supervisor of Human Resources: _____