

**County of Franklin  Request Leave**

Name: \_\_\_\_\_ Emp #: \_\_\_\_\_

Department: **PUBLIC SAFETY** Date: \_\_\_\_\_

# of Work Hours: \_\_\_\_\_ # of Work Days: \_\_\_\_\_

Beginning: \_\_\_\_\_ Ending: \_\_\_\_\_

- With Pay:                      Annual Leave
- Sick Leave
- Compensatory Leave
- Other (Specify Type) \_\_\_\_\_

Without Pay                      (Specify Type) \_\_\_\_\_

I certify I was unable to work from \_\_\_\_\_ to \_\_\_\_\_ due to personal illness or injury.

Date: \_\_\_\_\_ Employee Signature: \_\_\_\_\_

**\*TO BE FILLED OUT BY SUPERVISOR\***

Approved as Requested                      Request Denied

If request was denied, explain: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_ Supervisor Signature: \_\_\_\_\_