

## SICK/OTHER LEAVE FORM

Request Date

### Employee Information

Employee Name:

Contact Number:

Under Sponsorship of:

Department:

Position:

Direct Manager:

Who covered you:

### Absence Details

Type of Leave	Start Date	End Date	Total Days	Weekends/ Public Holidays	Total Number of Working Days Taken	Day Back

### Doctor Examination and Recommendation

  
  
  
  

Doctor's Signature and stamp:

Employee Signature

Direct Manager Signature

### To be completed by HR Department

Current Balance	Leave Days Taken	New Leave Balance	Date Resuming Duty	Comment

Received by

Approved by