

INSTRUCTION: This form should be filled out in 3 copies BEFORE and employee goes on leave.
In case of emergency or illness, this form must be filled out IMMEDIATELY upon return for work.
Sick leave application will only be honored provided it is a duty certified by licensed Physician.

☐ SL

☐ VL

☐ EL

☐ BL

☐ ML

☐ SPL

☐ OFFSET

EMPLOYEE NAME:		NAME OF RELIEVER:									
POSITION:		INCLUSIVE DATES:		M	M	D	D	Y	Y	Y	Y
DEPARTMENT:		RETURN TO WORK:		M	M	D	D	Y	Y	Y	Y
REASON:											
		RECOMMENDED BY:		CLEARED BY:				APPROVED BY:			
		<input type="radio"/> Approved <input type="radio"/> Disapproved		<input type="radio"/> Approved <input type="radio"/> Disapproved				<input type="radio"/> Approved <input type="radio"/> Disapproved			
Employee's Signature <small>(Signature over Printed Name)</small>		Immediate Superior <small>(Signature over Printed Name)</small>		HR Department <small>(Signature over Printed Name)</small>				KATHLEEN REYES, MHM, DBA Chief Operating Officer			
DATE SIGNED:		DATE SIGNED:		DATE SIGNED:				DATE SIGNED:			
TO BE FILLED OUT BY THE HRD DEPARTMENT:											
	SL	VL	EL	OS	BL	ML	PL	<input type="checkbox"/> WITH PAY <input type="checkbox"/> WITHOUT PAY			
Earned to date:								Remarks:			
Used to date											
This Leave											
Balance											

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		RECOMMENDED BY:		CLEARED BY:				APPROVED BY:			
		<input type="radio"/> Approved <input type="radio"/> Disapproved		<input type="radio"/> Approved <input type="radio"/> Disapproved				<input type="radio"/> Approved <input type="radio"/> Disapproved			
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