**Crossroads Counseling and Training Services**

### LEAVE REQUEST

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Leave Information | | | | | | | | | | | | | |
| Employee Name: | | | |  | | | | | | | | | |
| Team Leader: | | |  | | | | | | | | | | |
| Type of Absence Requested (Please check additional box if checking Time Off Without Pay Box): | | | | | | | | | | | | | |
|  |  | Sick | | | |  | Vacation |  | Bereavement | | |  | Time Off Without Pay |
|  |  | Military | | | |  | Jury Duty |  | Maternity/Paternity | | |  | FMLA |
| Worker’s Comp  Dates of Absence: From: | | | | | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  |  | | |
| Number of Leave Hours Requested:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expected Return Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dates of Holidays that occur during Absence:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  You will need to submit a work plan to each individual that will be covering any of your responsibilities. Put this information on the work plan for leave coverage form (on back). A copy of this form should be given to your supervisor or the executive director and the staff members that will be accepting responsibility for your normal work assignments. It is the employees’ responsibility to submit these forms at least two working days prior to your beginning date. Your leave approval may be canceled or delayed if this is not done. | | | | | | | | | | | | | |
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|  | | |  |
| Employee Signature | | | Date |
|  | | | |
| Team Leader Approval | | | |
|  |  | Approved | |
|  |  | Rejected | |

|  |  |
| --- | --- |
| Team Leader Signature | Date |

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| --- |
| Work Plan for Leave Coverage |
| Name of Employee going on Leave\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of staff accepting responsibility for Projects/Consumers during Leave\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of Consumer/Project requiring coverage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Identify dates and times and activities that are regularly scheduled:  Identify any special appointments and staffing requirements for accomplishing them:  State any additional information that would be helpful:  Your signature indicates that you have reviewed, understand and agree to complete this work plan:  Staff Member on Leave\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Covering Staff Member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Supervisor or Executive Director\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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