FAITH MEDICAL CENTRE
1 GIWA-AMU/AIRPORT ROAD
P.O. BOX 4307

AUTHORIZATION FOR LEAVE

Employee's Name _____ Hire Date _____

Your leave has been approved from _____ to _____.

Your duties resume _____.

Reason for leave:
_____ Annual _____ Sick _____ Funeral _____ Maternity _____ Others

_____ No. days paid leave _____ No. days unpaid leave

₦_____ Leave Bonus awarded

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Anniversary date _____ Days leave accrued _____

No. of days used _____ No. of days remaining _____