STAFF LEAVE APPLICATION FORM

Title: _____ Name:_____

Designation: _____

Department: _____

Reasons of Leave : _____

_____

_____

Leave Type: Paid ☐ Unpaid ☐ Annual ☐ Medical Leave ☐

Number of Days: _____ From Dated: __/___/___To: ___/___/___

Applicants Signature: _____ Date: _____

Manager Remarks:_____

Approved /Not Approved: _____

HR Remarks: _____

Approved /Not Approved: _____

Director's Signature: _____Dated: ___/___/_____