LEAVE WITHOUT PAY REQUEST FORM

Employee Name (Print Name): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Contact Number: _____ Email: _____

UNPAID TIME-OFF REQUESTED AS FOLLOWS:

_____ TO _____ # of Days: _____

Reason for Request (optional): _____

_____

_____

_____

Employee's Signature*: _____ Date: _____

*By signing above, you understand & agree to pay your portion of medical/dental benefits directly to ADAPP by the 10th of the month on leave.

Supervisor's Comments (Recommendation/program implications): _____

_____

_____

Supervisor's Signature: _____ Date: _____

Assistant Clinical Director's Recommendation & Comments:

□ Recommend Approval □ Recommend Disapproval

_____

_____

Assistant Clinical Director's Signature: _____ Date: _____

Anna to return this form to BriAna

Internal Notes: _____

_____

Approved By: _____ Date: _____

cc: Christine Cavallucci, Executive Director
BriAna Pechin, Chief Operating Officer
Employee Personnel File