

Leave Without Pay Form

Name:
ID Number:
Department:
Month:

Please List all Leave Without Pay Hours Taken:

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Hours																

Day	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
Hours																

I certify that the above hours are correct.

Employee Signature

Date

Department Head / Dean Signature

Department Head / Dean Name (Print)