Shoshone - Paiute Tribes, P.O. Box 219, Owyhee, Nevada 89832

Application for Leave

Name: ____
(last) (first) (middle initial)

From: ____________________ To: ____________________ ______________
(month) (day) (hour) (month) (day) (hour) (total hrs)

Type of Leave: [ ] Annual [ ] Sick [ ] Comp [ ] Without Pay [ ] Other

Comments: ____

____________________ ____________________
Employee Signature Date

ATTENTION EMPLOYEES: Any leave authorized in excess of the amount available to you during the pay period will be returned to your Supervisor.

**Supervisor may request that this section be completed if applying for three or more days.

CERTIFICATE OF PHYSICIAN

Name: ______________________________

From: ____________________ To: ____________________ ______________
(month) (day) (hour) (month) (day) (hour) (total hrs)

The above named employee was under my professional care during the period above his/her condition during the period was such that I considered it inadvisable for him/her to report to work.

____________________ ____________________
Doctor’s Signature Date

OFFICIAL ACTION ON LEAVE APPLICATION

[ ] APPROVED [ ] DISAPPROVED (please state reason)

____________________ ____________________
Supervisor’s Signature Date