

LICENSE REQUEST

NAME: _____

DATE: _____

DEPARTMENT: _____

EMPLOYEE # _____

SOCIAL SECURITY NO. _____

LICENSE BEING REQUESTED

MATERNITY SICKNESS VACATIONS WITHOUT SALARY OTHERS

AMOUNT OF DAYS: _____ FROM _____

TO _____

EMPLOYEE COMMENTS:

EMPLOYEE'S SIGNATURE

SUPERVISOR COMMENTS:

SUPERVISOR'S SIGNATURE

APPROVED: _____
HUMAN RESOURCES DEPARTMENT