

Cook County Application for Leave

Department: _____

INSTRUCTIONS

- 1- This form must be submitted on any absence from scheduled work.
- 2- Separate forms are to be submitted for each type of leave required.
- 3- This form must be submitted prior to the leave requested except for sick leave as indicated below or in cases of emergency.
- 4- Approval of the requested leave is not granted until all required signatures are affixed to this form.
- 5- Employees must report to the person and/or place designated for their unit within the time established for their department/division, to report any absence not previously approved. Failure to so report may result in loss of leave benefits and/or appropriate disciplinary action.
- 6- Sick leave benefits are governed by the provisions of the Cook County Personnel and Policies Manual.
- 7- NOTICE - "Falsification of either a written, signed statement or a physician's certificate shall be grounds for disciplinary action including dismissal."

NAME: _____ **DATE:** _____

TIME

I hereby apply for _____ hours of the following type leave:

Annual Leave Sick Leave

Beginning Date: _____ AM _____ PM

And

Ending Date: _____ AM _____ PM

Complete the following when applying for sick leave:

Incapacitated by illness or injury Undergoing Medical, Dental or Other Treatment

Required to care for a Family Member _____
Name & Relationship

Death of a Family Member _____
Name & Relationship

Note: Sick leave may be used up to 3 days for the death of a family member as specified under Section 16 item G 2 of the Cook County Policy and Procedures Manual.

DOCTOR COMPLETES

Physician's Certificate: If medical attention is required or the absence extends beyond three working days or if a certificate is required by supervisor, a licensed physician must certify the necessity for sick leave. Failure to obtain this certification may result in denial of sick pay benefits and/or disciplinary action.

(Employee's Name) _____ was under my care during the period noted above and is hereby released to return to full duty as a/an (Employee's Position) _____ with Cook County effective (Date) _____.

Physician's Signature

Date

EMPLOYEE'S STATEMENT

I hereby declare that the personal data provided in this application is true, correct and complete to the best of my knowledge and belief. I fully understand that a false entry shall be grounds for disciplinary action including dismissal.

Signature - Do not print or type

SUPERVISOR COMPLETES

Disposition:

The leave requested above is approved, denied, with, without pay.

Reason for denial: _____

Supervisor: _____ **Date:** _____

Granting Authority: _____ **Date:** _____