UNIVERSITY *of* NORTH ALABAMA

Police Department

REQUEST FOR LEAVE OR APPROVED ABSENCE/COMPENSATORY (COMP) TIME

1. **NAME** *(Last, First, Middle Initial)*	2. **EMPLOYEE OR SOCIAL SECURITY NUMBER**

3. **REQUEST FOR COMPENSATORY (COMP) TIME** *(Check appropriate box below)*	**DATE** From:	To:	**TIME** From:	To:	**TOTAL HOURS**	5. **PURPOSE**
☐ **Compensatory Time Earned**						

4. **TYPE OF LEAVE/ABSENCE** *(Check appropriate box(es) below)*	**DATE** From:	To:	**TIME** From:	To:	**TOTAL HOURS**	5. **FAMILY AND MEDICAL LEAVE**
☐ **Accrued Annual Leave**						*If annual leave, sick leave, or leave without pay will be used under the Family and Medical Leave Act of 1993, please provide the following information:*
☐ **Advance Annual Leave**						
☐ **Accrued Sick Leave**						☐ **I hereby invoke my entitlement to Family and Medical Leave for:**
☐ **Advance Sick Leave**						☐ Birth/Adoption/Foster Care ☐ Serious Health Conditions of Spouse, Son, Daughter, or Parent ☐ Serious Health Condition of Self
Purpose: ☐ Medical/dental/optical examination of requesting employee ☐ Other ☐ Care of family member/bereavement, including medical/dental/optical examination of family member						
☐ **Compensatory Time Off**						*Contact your supervisor and/or your personnel office to obtain additional information about your entitlements and responsibilities under the Family and Medical Leave Act of 1993.*
☐ **Other Paid Absence**						
☐ **Leave Without Pay**						

6. **REMARKS**

7. **CERTIFICATION:** I hereby request leave/approved absence from duty as indicated above and certify that such leave/absence is requested for the purpose(s) indicated. I understand that I must comply with my employing agency's procedures for requesting leave/approved absence (and provide additional documentation, including medical certification, if required) and that falsification of information on this form may be grounds for disciplinary action, including removal.

EMPLOYEE SIGNATURE **DATE**

8. **SUPERVISOR ACTION:** ☐ **APPROVED** ☐ **DISAPPROVED** *(If disapproved, give reason. If annual leave, initiate action to reschedule.)*

SIGNATURE **DATE**

PRIVACY ACT STATEMENT

The primary use of this information is by management and your payroll office to approve and record your use of leave. Additional disclosures of the information my be: To the Department of Labor when processing a claim for compensation regarding a job connected injury or illness; to a State unemployment compensation office regarding a claim; to Life Insurance or Health Benefits carriers regarding a calim; to a Federal, State, or local law enforcement agency when your agency becomes aware of a violation or possible violation of civil or criminal law; to a Federal agency when conducting an investigation for employment or security reasons;

Where the employee identification number is your Social Security Number, collection of this information is authorized by Executive Order 9397. Furnishing the information on this form, including your Social Security Number, is voluntary, but failure to do so may result in disapproval of this request.