

FAUQUIER COUNTY
REQUEST FOR LEAVE

NAME: _____

DEPARTMENT: _____ PROGRAM: _____

TYPE OF LEAVE:

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> Annual | <input type="checkbox"/> Bereavement | <input type="checkbox"/> Compensatory |
| <input type="checkbox"/> Sick | <input type="checkbox"/> Without pay | <input type="checkbox"/> Floating Holiday |
| <input type="checkbox"/> Injury/Illness in line of duty | | <input type="checkbox"/> Other (specify) |

TO BEGIN:

HOUR	a.m.	Month	Day	Year	
	p.m.				

Month	Day	Year

TO END:

HOUR	a.m.	Month	Day	Year	
	p.m.				

Month	Day	Year

TOTAL HOURS

--

REMARKS: _____

EMPLOYEE SIGNATURE: _____

SIGNATURE OF SUPERVISOR: _____

- APPROVED DISAPPROVED*

Date: _____

Date: _____

*Show reason(s) under remarks.

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