

CH-1A (9/87)

LOCAL HEALTH DEPARTMENT  
EMPLOYEE LEAVE / OVERTIME REQUEST FORM

Local Health Department \_\_\_\_\_

LHD ID# \_\_\_\_\_

Health Center \_\_\_\_\_

Employee Class ID# \_\_\_\_\_

I request \_\_\_\_\_ hour(s) leave for the period:

Beginning

\_\_\_\_\_ 20 \_\_\_\_\_

Hour

Month

Day

Year

I request \_\_\_\_\_ hour(s) overtime for the period:

Ending

\_\_\_\_\_ 20 \_\_\_\_\_

Hour

Month

Day

Year

CHARGE LEAVE TO:

- ANNUAL
- SICK
- COMPENSATORY
- OTHER PAID
- WITHOUT PAY

PURPOSE: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant                      Date                      Signature of Supervisor                      Date

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Signature of Applicant                      Date                      Signature of Supervisor                      Date