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 ___________ Hour ___________ Month _________ Day 20 ________ Year

I request __________ hour (s) overtime for the period: Ending ___________ Hour ___________ Month _________ Day 20 ________ Year

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CHARGE LEAVE TO:

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

PURPOSE: ____

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Signature of Applicant ____________ Date ________ Signature of Supervisor ____________ Date ________