WHITE MOUNTAIN APACHE TRIBE
REQUEST FOR LEAVE PAYMENT

DATE ____________________

LAST NAME, FIRST, M.I.	DEPARTMENT/ENTERPRISE/PROGRAM	SOCIAL SECURITY NO.

NOTE: LEAVE AUTHORIZAION IN EXCESS OF THAT TO YOU CREDIT WILL BE CHARGED TO LEAVE WITHOUT PAY.

TYPE OF LEAVE	DATE FROM	DATE TO	TOTAL HOURS REQUESTED

IF YOUR ILLNESS WAS IN EXCESS OF TWO (2) DAYS, YOU MUST HAVE YOUR PHYSICIAN COMPLETE THE FOLLOWING INFORMATION AND HAVE THE SIGNATURE OF THE SAME.

THE ABOVE NAMES EMPLOYEE OF THE **WHITE MOUNTAIN APACHE TRIBE** WAS UNABLE TO WORK DUE TO THE FOLLOWING REASON:

UNABLE TO WORK:

FROM ____________ TO ____________

SIGNATURE OF PHYSICIAN | PHONE | DATE

SIGNATURE OF APROVING OFFICER	SIGNATURE OF EMPLOYEE
DATE	DATE

ATTACH TO TIME SHEET

PERSONNEL AUTHORIZATION ____________________