FORM PD-8 Rev. 8/96 P&P WHSE STOCK NO. 4480

**STATE OF NEW HAMPSHIRE**

# APPLICATION FOR LEAVE

DEPARTMENT _____ DATE _____

I, _____ request leave as follows:
(Applicant Signature)

Social Security Number _____

| TYPE OF LEAVE | BEGINNING | | ENDING | | TOTAL HOURS |
|---|---|---|---|---|---|
| | DATE | TIME | DATE | TIME | |
| | | | | | |
| | | | | | |
| | | | | | |

**TYPE OF LEAVE:** ANNUAL COMPENSATORY FMLA SICK
OTHER BONUS EDUCATIONAL MILITARY SICK-DEPENDENT
CIVIL FY BONUS FLOATING HOLIDAY WITHOUT PAY SICK-FUNERAL

**RESPONSE TO EMPLOYEE REQUESTING LEAVE:**

☐ **Recommended**
☐ **Not Recommended**

☐ **Approved**
☐ **Not Approved**

_____
**Immediate Supervisor** **Date**

☐ **Unauthorized Use of Leave**
☐ **W.P.**
☐ **W/O.P.**

_____
**Officer Authorized to Approve Leave** **Date**

_____
**Signature for Audit Purposes Only** **Date**

**CERTIFICATE REQUIRED FOR SICK LEAVE**

I certify that I was incapacitated or for other reasons specified within the provisions of sick leave benefits, was unable to attend to my official duties for the time indicated.

_____
State Reason for Leave

Signature _____ Date _____

**SHOULD AN EMPLOYEE BE REQUIRED BY THE EMPLOYER TO FURNISH THE EMPLOYER WITH A CERTIFICATE FROM AN ATTENDING PHYSICIAN OR OTHER LICENSED HEALTH CARE PRACTITIONER, SUCH CERTIFICATE SHALL BE AS FOLLOWS:**

I, _____ , a physician or other licensed health care practitio-

ner, whose office is located at _____ ,
(Office Address)

do hereby certify that _____ above named,

was incapacitated from _____ to _____ inclusive and during such time

due to _____ .

_____ _____
(Signature of Physician or Licensed Health Care Practitioner) (Date)