



EMPLOYEE LEAVE FORM

Complete thoroughly. Employee and Supervisor must sign. Route completed, signed form to HR with other applicable forms. For complete package of required forms, contact HR.

Name _____ Department _____

NOTE: If you are going on STD, please make sure to answer the question below marked with an asterisk (*)

| TYPE OF LEAVE | DATE(S) M/D/Y | # HOURS |
|---|------------------|---------|
| Vacation Leave | | |
| Personal Leave | | |
| Comp. Time Used | | |
| Floating Holiday | | |
| Birthday Leave | | |
| Jury Duty | | |
| Death in Family | | |
| Sick Bank <small>(from frozen bank, available after personal bank is exhausted or qualify for STD)</small> | | |
| Short Term Disability (STD) <small>(after 7 days)</small> | | |
| Leave of Absence without pay under 30 days <small>(over 30 requires form and board approval)</small> | | |
| Work Related Accident/Illness | | |
| Disciplinary Leave | | |
| Unexcused Absence | | |
| Excused: Explain below | | |

* While on approved STD I wish to use my additional available vacation, personal, comp and/or floating time (if any) to supplement my STD (in addition to what I may have requested above for the waiting period.) **Circle YES or NO**

Note that per Mutual of Omaha policy, you may not use sick time, only vacation, personal, comp or floating holiday that is not specified as sick leave.

Name of Physician if requested: _____

Comment: _____

Signature of Employee: _____ Date: _____

Signature of Supervisor: _____ Date: _____