

# LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER



## Neuroscience Center of Excellence

Employee's Name \_\_\_\_\_

This is a request for \_\_\_\_\_ hours of leave for the period:

beginning \_\_\_\_\_ am/pm on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

and ending \_\_\_\_\_ am/pm on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Type of Leave

- Annual                       Sick                       Straight Compensatory
- Leave without Pay       Other

Reason for Leave:

1. \_\_\_\_\_ Own illness or injury
2. \_\_\_\_\_ Own medical treatment or consultation
3. \_\_\_\_\_ Care for child, spouse or parent who has a serious health condition
4. \_\_\_\_\_ Care for child after birth, or placement of a child for adoption or foster care
5. \_\_\_\_\_ Pre-natal care
6. \_\_\_\_\_ Personal business or family matters not covered in 1-4
7. \_\_\_\_\_ Other (list reason in remarks section)

Remarks:

I CERTIFY THAT MY ABSENCE FROM DUTY WAS FOR THE REASON NOTED

Date

Employee Signature

Employee's Supervisor/Title

Nicolas G. Bazan, Director