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 practitioner, 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)