

State of New York
OFFICE OF MENTAL HEALTH
REQUEST FOR TIME OFF DUTY

Name of Employee.

Item No.

Days to Be Charged to

Period

From _____ to _____
(Inclusive)

Total No. of Hours _____

Vacation _____

Leave Without Pay _____

Personal Leave _____

Leave With 1/2 Pay _____

Pass Days _____

Other Leave _____

Sick Leave _____

(Explain Below)

Comments (Where Required—Enter Reason for Request. Explain "Other Leave")

Date

Title

Signature

Approved

Disapproved

Date _____

Approved

Disapproved

Date _____

DIRECTOR

SUPERVISOR OR DEPARTMENT HEAD