EBAYC

Where young people grow, thrive and lead!

EMPLOYEE LEAVE AUTHORIZATION

Date of this Request: _____

Employee Name: _____

Type of Request: ☐ Vacation   ☐ Medical   ☐ Bereavement   ☐ Unpaid

☐ PFL (Paid Family Leave)   ☐ SDI (State Disability Leave)

Current Vacation Leave Balance		**Current Medical Leave Balance**	
Supervisor Initials to confirm balance		*Supervisor Initials to confirm balance*	

	Requested Dates -From-		Requested Dates -To-	Total Number of Days Requested	Total Number of Hours Requested
1)		to			
2)		to			
3)		to			
4)		to			
5)		to			
6)		to			
7)		to			

Date of Return to Work: _____

_____
Supervisor's Signature

___ / ___ / _____
Date of Approval

_____
Director of Operation's Signature

___ / ___ / _____
Date of Approval

Revised 07/2020