

Sam Houston State University Human Resources

Leave Request/Approval Form

Employees must complete this form in advance for leaves and other absence from duty. This form should be complete with the type of leave, dates of absence, number of hours requested, and required documentation attached before it is forwarded through the administrative channels for approval. Please check Banner Self-Service (SSB) on MySam for your leave balances. If you are still unsure of your current leave balances, please contact Payroll.

Name: _____ Sam ID: _____
Address: _____ Home/Cell#: _____
Job Title: _____ Department: _____
Supervisor Name: _____ Supervisor Phone #: _____

Leave Categories:

_____*Administrative Performance Leave
_____*Bereavement Name/Relationship: _____, date occurred: _____
_____*Blood Donation _____*Certified Red Cross Activities _____*Emergency
_____*Foster Parent Leave _____*Jury Duty/Witness _____*Leave Without Pay
_____*Military _____*Organ/Bone Marrow Donor _____*Parent/Teacher Conference Leave
_____*Sick ☐ Self ☐ Family Name/Relationship of Family Member: _____
Does this apply to FMLA/Parental Leave? ☐ Yes ☐ No
If yes, does your Spouse work for a Texas State Agency? ☐ Yes ☐ No If yes, what Agency? _____
_____*Training for Disability _____Vacation _____Voting
**Attach supporting documentation. **Sick Leave absences for more than 3 consecutive days requires medical certification. Refer to Human Resources Policy B-1, Employee Leaves, for additional details and information about eligibility and usage.*

Type of Leave Requested:	Dates of Absence:	# of hours:
_____	____/____/____ - ____/____/____	_____ hours
_____	____/____/____ - ____/____/____	_____ hours
_____	____/____/____ - ____/____/____	_____ hours
_____	____/____/____ - ____/____/____	_____ hours

Completed medical certification (if applicable): ☐ Was submitted to Human Resources. ☐ Will be submitted to Human Resources.
☐ Check here if **Other Assigned Duty Point Work Arrangement** will be requested***
☐ Check here if leave is in conjunction with the **SHSU Worker's Compensation Return-To-Work Program**.

***Approval must be received from the Department Head, Associate Vice President for Human Resources and Risk Management, and Divisional Vice President.

Employee Acknowledgement & Signature

I certify that the information above is accurate. I understand I will need to notify my supervisor, department, and/or Human Resources immediately should the status of my leave change. I understand it is my responsibility to submit all proper documents regarding this request. If I am not able to return the required documentation within the allowed timeframe, I will contact Human Resources for assistance. My anticipated return to work date will occur on _____.

Employee: _____ Date ____/____/____

Supervisor Approval:

As the supervisor of the employee listed above, I am aware that the employee has applied for leave as indicated above. I will notify Human Resources immediately if I become aware of any changes to the information provided.

Supervisor: _____ ☐ Approved ☐ Disapproved Date ____/____/____

Administrative Approvals:

Dept. Head/Chair: _____ ☐ Approved ☐ Disapproved Date ____/____/____

Dean (if applicable): _____ ☐ Approved ☐ Disapproved Date ____/____/____

Vice President: _____ ☐ Approved ☐ Disapproved Date ____/____/____

Human Resources: _____ ☐ Approved ☐ Disapproved Date ____/____/____

President: _____ ☐ Approved ☐ Disapproved Date ____/____/____
(Administrative Performance /Emergency Leave only)

Comments: _____

