

# Black Hills Special Services Cooperative

## Leave Request

Employee Name: \_\_\_\_\_  
(Please Print)

Date (s) of Leave \_\_\_\_\_  
(Specify length of time and/or hours of leave)

Number of Hours/Days of leave Requested: \_\_\_\_\_

Current leave balance for requested type of leave: \_\_\_\_\_

††Time off without pay: \_\_\_\_\_

Classification & Type of Leave Requested:

Class 1  
\_\_\_ Sick\*\*

Class 2  
\_\_\_ Sick\*\*  
\_\_\_ Annual

Class 4 Hourly 20+  
\_\_\_ PPL

Class 4 Hourly Part-Time

††Time off without pay requires prior approval from your supervisor and/or the program director. Please contact your supervisor regarding time off if you do not have enough leave or are among a class of employees who do not earn leave.

Reason for Sick Leave \_\_\_\_\_

\*\* The Family Medical Leave Act entitles eligible employees to take up to 12 weeks of unpaid, job-protected leave in a 12-month period for specified family and medical reasons. Please review the Personnel Policy & Procedures Manual or contact the payroll department for more information.

Employee Signature

Date

\_\_\_ Approved

\_\_\_ Disapproved

\_\_\_\_\_  
Supervisors Signature

\_\_\_\_\_  
Date