THE MEDICAL EYE CENTER

Gagan J. Singh, M.D.

710 Somerset Blvd., Suite 101
Charles Town, WV 25414
(304) 725-2121

Request for Leave

Name: _____. Date Submitted: _____

Pay Period Dates: _____

Date(s) requested (Must be within the Pay Period)

Week One		Week Two	
☐ Mon	_____	☐ Mon	_____
☐ Tue	_____	☐ Tue	_____
☐ Wed	_____	☐ Wed	_____
☐ Thur	_____	☐ Thur	_____
☐ Fri	_____	☐ Fri	_____

Total Number of hours to be taken within this pay period: _____

Request is for: ○ Vacation ○ Personal ○ Sick ○ Other

If other, please explain: _____

_____

_____
Employee Signature Date

ADMINISTRATIVE USE ONLY

Date Received:

☐ Approved ☐ Denied

_____

Supervisor Signature **Date**