

APPLICATION FOR LEAVE



To be completed by the employee and referred to your head of department. Please ensure relevant sections are completed and appropriate boxes are checked. PLEASE PRINT CLEARLY.

EMPLOYEE DETAILS:

Surname: _____ Other Names: _____
 Employee Number: _____ Department: _____
 Campus: _____ Contact Number: _____

EMPLOYEE STATUS: Full time: Part time: Sessional: Casual:
 Number of hours worked per fortnight: _____ **Autopay Employee:** Yes: No:

TYPE & AMOUNT OF LEAVE APPLIED FOR:

<input type="checkbox"/> Annual _____ hours <input type="checkbox"/> ADO _____ hours <input type="checkbox"/> Public holiday _____ hours <input type="checkbox"/> Family / Carers * _____ hours <input type="checkbox"/> Sick* <input type="checkbox"/> No Cert <input type="checkbox"/> Stat Decl* _____ hours <input type="checkbox"/> 4 Clear days provision _____ days <input type="checkbox"/> Special / Other ** _____ hours <input type="checkbox"/> Study <input type="checkbox"/> EBA Study _____ hours	<input type="checkbox"/> Professional Development _____ hours <input type="checkbox"/> Exam _____ hours <input type="checkbox"/> Compassionate ** _____ hours g Conference Refer to "Application for conference / training leave" form <input type="checkbox"/> Long service full pay *** _____ weeks <input type="checkbox"/> Long service double pay *** _____ weeks <input type="checkbox"/> Long service half pay *** _____ weeks g Parental Leave Refer to "Application for parental / adoption" form
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* Please attach supporting documentation
 ** Please provide details of leave in comments section of this form.
 *** Minimum period of LSL cannot be less than 1 week. (7 calendar days). Leave date must be negotiated with Dept.

TOTAL WORKING ABSENCE:

First date of leave: _____ Last date of leave: _____
 Resume duties on: _____ Total leave hours applied for: _____

Do you require prepayment of leave? Yes: No:

**** If YES, form must be lodged 4 weeks prior to commencement of leave. ****

Do you work a rotating roster? Yes: No: **If YES, the projected roster below must be completed.**

****PROJECTED ROSTER FOR ANNUAL LEAVE****

Please indicate in the relevant box, your proposed hours per shift and scheduled roster (ie. Early = E, Late = L, Night = N, Permanent Night = P, Rostered Off = O). Also indicate any ADO or public holiday on actual dates.

FORTNIGHT	MON	TUES	WED	THUR	FRI	SAT	SUN	MON	TUES	WED	THUR	FRI	SAT	SUN

Comments: _____

Employee signature: _____ **Date:** _____
Divisional Director/Dept Manager Name: _____ **Ext:** _____ **Date:** _____
Divisional Director/Dept Manager Signature: _____ **Actioned by Payroll Services:** _____ **Date:** _____