# WHITE MOUNTAIN APACHE TRIBE
## REQUEST FOR LEAVE PAYMENT

DATE ____________________

| LAST NAME, FIRST, M.I. | DEPARTMENT/ENTERPRISE/PROGRAM | SOCIAL SECURITY NO. |
|---|---|---|
| | | |

**NOTE: LEAVE AUTHORIZAION IN EXCESS OF THAT TO YOU CREDIT WILL BE CHARGED TO LEAVE WITHOUT PAY.**

| TYPE OF LEAVE | DATE FROM | DATE TO | TOTAL HOURS REQUESTED |
|---|---|---|---|
| | ____________ | ____________ | ____________ |
| | ____________ | ____________ | ____________ |
| | ____________ | ____________ | ____________ |
| | ____________ | ____________ | ____________ |

IF YOUR ILLNESS WAS IN EXCESS OF TWO (2) DAYS, YOU MUST HAVE YOUR PHYSICIAN COMPLETE THE FOLLOWING INFORMATION AND HAVE THE SIGNATURE OF THE SAME.

THE ABOVE NAMES EMPLOYEE OF THE **WHITE MOUNTAIN APACHE TRIBE** WAS UNABLE TO WORK DUE TO THE FOLLOWING REASON:

**UNABLE TO WORK:**

FROM ____________ TO ____________ ____________ ____________ ____________

SIGNATURE OF PHYSICIAN | PHONE | DATE

| SIGNATURE OF APROVING OFFICER | SIGNATURE OF EMPLOYEE |
|---|---|
| DATE | DATE |

**ATTACH TO TIME SHEET**

PERSONNEL AUTHORIZATION ____________________