J & D INSTITUTE OF NURSING

Faculty Leave Request Form

Date: _____

Name: _____

Type of Leave Requested:

- ☐ Casual Leave
- ☐ Sick Leave
- ☐ Leave Without Pay
- ☐ Paternity Leave
- ☐ Duty Leave
- ☐ Compensatory Leave
- ☐ Maternity Leave
- ☐ Other (please specify)

Start Date of Leave: _____

End Date of Leave: _____

Total Number of Days Requested: _____

Reason for Leave: (Please be as specific as possible)

_____

Duties Handed Over To:

Responsibility: Faculty Name & Signature:

1)_____

2)_____ _____

Signature of Duty Taker Administrator Principal