

**Borough of Manhattan Community College
Office of Human Resources Application for
Leave**

Name: _____ Department: _____

Type of Leave: **Annual**
 Compensatory
 Unscheduled Holiday
 Sick
 Temporary Disability Leave
 (Medical Documents submitted
 to HR: Yes () No ())

From: _____ To: _____

Total days/hours: _____

Employee's Signature

Date

Signature of Approving Officer

Date

Signature of Division VP/Dean

Date

**Note: I. Signature of Division VP/Dean is required when Leave
request in excess of 10 consecutive Workdays**

**II. For classified employees, where an illness is in excess of 3
consecutive work days, an original physician's certificate
must be presented upon return.**

**III. For instructional staff employees, where an illness is in
excess of 5 consecutive work days, an original physician's
certificate must be presented upon return.**

**IV. Application for all leaves must be submitted to the Office
of Human Resources prior to the beginning of the leave date.**