

**University of North Texas Health Science Center at Fort Worth  
Leave Form**

(See following page for instructions and example of completion)

NAME \_\_\_\_\_ EMPLID \_\_\_\_\_

DEPARTMENT NAME \_\_\_\_\_ DEPARTMENT NUMBER \_\_\_\_\_

Leave Requested	Code	Other Information Required	Approval Level
Vacation	VAC		B
Sick Leave	SCK		B
Jury Duty	JUR	Attach Summons	B
Witness Duty	JUR	Attach Summons	B,C
Emergency Leave (up to 3 days)	EMG	Relationship	B,C,
Emergency Leave (more than 3 days)	EMG	Relationship	B,C,F
Administrative Leave	ADM	Reason for Leave	B,C,F
Academic Leave	DEV	Purpose & Emergency Contact	B,D
Leave without Pay (up to 6 weeks)	DOC	Reason for Leave	B
Leave without Pay (more than 6 weeks)	DOC	Reason for Leave	B,F
Military Leave	MIL	Attach Orders	B,C
Sick Leave Pool	SPT	Attach HRM-68	B,C
Compensatory Time taken @ 1.0	CT 1		B
Compensatory Time taken @ 1.5	CT5		
Other Leave	OL	Reason for Leave	B,C
Dock	DOC		B
Faculty / Staff Fitness Program	FSF		B
University Administration Leave	UNVAD		B

Required Information: \_\_\_\_\_

Emergency Contact Location: \_\_\_\_\_

**For Clinical Providers:**

Will provider coverage be needed? YES NO Covering Provider(s) \_\_\_\_\_

*Note: Providers are responsible for arranging coverage if the request is made less than 60 days in advance.*

Will clinics/appointments need to be canceled or rescheduled? YES NO Clinic Make-up Session Date(s) \_\_\_\_\_

**Form should be signed by Department Chair and a copy routed to the Executive Director for Clinical Operations.**

MONTH/YEAR \_\_\_\_\_

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

\_\_\_\_\_  
(A) STAFF MEMBER / FACULTY MEMBER      DATE

\_\_\_\_\_  
(B) DEPT CHAIR / SUPERVISOR                      DATE

\_\_\_\_\_  
(C) HUMAN RESOURCE SERVICES              DATE

\_\_\_\_\_  
(D) ASSOCIATE DEAN                              DATE

\_\_\_\_\_  
(E) DEAN    DATE

\_\_\_\_\_  
(F) PRESIDENT                                      DATE

