

NAME (LAST)		(FIRST)	(MIDDLE INITIAL)	DATE
ORGANIZATIONAL UNIT				EMPLOYEE NO.
TYPE OF LEAVE		(FOR FUNERAL COMPLETE REVERSE)		
Vacation	Sick*	Without Pay (15 Days or less)	Other (Specify)	
NO. OF HOURS	FROM (DATE & HOUR)		TO (DATE & HOUR)	
<p>*I certify that this absence was due to illness which incapacitated me for duty Medical, dental, or optical treatment by:</p> <p>Name of Practitioner:</p>			SIGNATURE OF EMPLOYEE	
			APPROVED (SUPERVISOR)	
			APPROVING OFFICER	
<b>COMPLETE REVERSE SIDE AS REQUIRED BY DEPARTMENTAL REGULATIONS</b>				
82-S-14 (Rev. 4/2020)		<b>LEAVE REQUEST</b>		CITY OF PHILADELPHIA

## CERTIFICATION OF PHYSICIAN OR PRACTITIONER

NAME OF EMPLOYEE

I certify that above employee was under my professional care.

FROM (MO., DAY, YR.)

THRU (MO. DAY, YR.)

DIAGNOSIS OR REMARKS

DATE OF RETURN TO DUTY

SIGNATURE

ADDRESS OF PHYSICIAN OR PRACTITIONER

DATE

## FUNERAL LEAVE CERTIFICATION

THIS IS TO CERTIFY I ATTENDED THE FUNERAL OF

RELATIONSHIP

LOCATION OF FUNERAL SERVICES (NAME AND ADDRESS)