**FAZAIA MEDICAL COLLEGE**

**AIR UNIVERSITY**

# LEAVE APPLICATION FORM (STAFF)

(Filling of all column is mandatory)

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Position:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Department:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Leave requested from** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**to** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Number of Days:** \_\_\_\_\_

**Leave Type:** Casual Annual Medical Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reasons for Current Leave**  \_\_

Date: Applicant Signature

**Duties will be performed by (Reliever Name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date: Signature

**Remarks by HoD: Approved/Recommended /Not Approved/ Not Recommended**

Note: HOD can approve casual leave upto 04 Days and recommend the remaining.

Date: Signature & Seal

**Remarks by HR: (Entitled/ Not Entitled)**

Date: Signature & Seal

**Remarks by the Vice Principal :( Recommended/Not Recommended)**

Date: Signature & Seal

**Remarks by the Principal FMC: (Approved / Not Approved)**

Date: Signature & Seal

Note: Please submit the approved application form to HR Department for record in Biometric as well.