Sick Leave Request Form

Employee Information

- **Full Name:** _____
- **Job Title:** _____
- **Department:** _____
- **Employee ID:** _____
- **Contact Number:** _____
- **Email Address:** _____

Sick Leave Details

- **Start Date:** _____
- **End Date:** _____
- **Number of Sick Days:** _____

Medical Information

- **Nature of Illness:** _____
- **Doctor's Note Attached:** ☐ Yes ☐ No

Supervisor Approval

Approver	Status	Comments	Signature
Supervisor	☐ Approved ☐ Denied	_____	_____
Supervisor	☐ Approved ☐ Denied	_____	_____

Supervisor	☐ **Approved** ☐ **Denied**	_____	_____
Supervisor	☐ **Approved** ☐ **Denied**	_____	_____

Employee Signature

- **Signature:** _____
- **Date:** _____

Medical Provider Information (if applicable)

- **Doctor's Name:** _____
- **Contact Number:** _____
- **Address:** _____