

**MCINTOSH TRAIL CSB  
REQUEST TO SOLICIT DONATED LEAVE**

Name \_\_\_\_\_ Date \_\_\_\_\_

Amount of Leave Requested \_\_\_\_\_

LWOP: Beginning date \_\_\_\_\_ Ending date \_\_\_\_\_

Reason that leave is needed: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Center Director Signature \_\_\_\_\_ Date \_\_\_\_\_  Approved  Denied

\_\_\_\_\_  
Personnel Manager \_\_\_\_\_ Date \_\_\_\_\_  Approved  Denied

If medical documentation has not previously been submitted, the Certification of Health Care Provider form (Attachment #2) must be completed and included with this request.