NAME *(LAST)*	*(FIRST)*	*(MIDDLE INITIAL)*	DATE
Kuhn	Olive	E	10/25/2024

ORGANIZATIONAL UNIT	EMPLOYEE NO.
Office of Worker Protections	302583

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)*
3	10/17/24 9:00 am	10/17/24 12:00 pm

*I certify that this absence was due to

☐ illness which incapacitated me for duty

☐ Medical, dental, or optical treatment by:

Name of Practitioner:

SIGNATURE OF EMPLOYEE

Olive Kuhn

Digitally signed by Olive Kuhn
Date: 2024.10.25 09:50:46 -04'00'

APPROVED (SUPERVISOR)

COMPLETE REVERSE SIDE AS REQUIRED BY DEPARTMENTAL REGULATIONS

APPROVING OFFICER

82-S-14 (Rev. 4/2020)

LEAVE REQUEST

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)*	