NAME *(LAST)*	*(FIRST)*	*(MIDDLE INITIAL)*	DATE
Chang	Edward		10/25/2024
ORGANIZATIONAL UNIT			EMPLOYEE NO.
Labor			252749

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)*
11.5	10/24/24 10:30 AM	10/25/24 4:00 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

E Chang

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)*	