NAME *(LAST)*	*(FIRST)*	*(MIDDLE INITIAL)*	DATE
Chang	Edward		10/24/2024

ORGANIZATIONAL UNIT	EMPLOYEE NO.
Labor	252749

TYPE OF LEAVE *(FOR FUNERAL COMPLETE REVERSE)*

- [x] Vacation
- [ ] Sick*
- [ ] Without Pay (15 Days or less)
- [ ] Other (Specify)

NO. OF HOURS	FROM *(DATE & HOUR)*	TO *(DATE & HOUR)*
7.5	11/25/24	11/25/24

*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

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)*	