NAME *(LAST)*	*(FIRST)*	*(MIDDLE INITIAL)*	DATE
Paumard	Romain		10/08/2024
ORGANIZATIONAL UNIT			EMPLOYEE NO.
Office of Worker Protections (DOL)			299691

TYPE OF LEAVE *(FOR FUNERAL COMPLETE REVERSE)*

☐ Vacation ☐ Sick* ☐ Without Pay (15 Days or less) ☑ Other (Specify) Jury Duty

NO. OF HOURS	FROM *(DATE & HOUR)*	TO *(DATE & HOUR)*
7.5 hours	11/13/24 8am	11/13/24 3:30pm

*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

Romain Paumard

APPROVED (SUPERVISOR)

APPROVING OFFICER

COMPLETE REVERSE SIDE AS REQUIRED BY DEPARTMENTAL REGULATIONS

82-S-14 (Rev. 4/2020) **LEAVE REQUEST** CITY OF PHILADELPHIA