UNIVERSITY OF THE
PACIFIC

EXEMPT STAFF MEDICAL OR DISABILITY LEAVE REPORTING FORM

MONTH: _____

EMPLOYEE NAME:	EMPLOYEE NUMBER: 98
TITLE:	LEAVE START DATE:
DEPARTMENT:	SUPERVISOR:

DATE	LEAVE HOURS	DATE	LEAVE HOURS
Date		Date	
Date		Date	
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Date		Date	
Date		Date	

EMPLOYEE SIGNATURE:	DATE:
SUPERVISOR SIGNATURE:	DATE:

Due to the Benefits Specialist in Human Resources (STK) by the 1st of the following month