Medical Leave Request Form

Employee Information

Full Name:

Employee ID:

Department:

Leave Details

Leave Start Date:

Leave End Date:

Total Number of Days:

Medical Reason / Doctor's Note:

Provide details and attach a doctor's note if applicable.

Contact Information During Leave

Preferred Contact (Phone/Email):

Declaration

☐ I confirm that the information provided above is accurate and I am applying for medical leave as required.

Submit Request