FORM 69 ADM. (MH) (4~78)

State of New York
OFFICE OF MENTAL HEALTH
REQUEST FOR TIME OFF DUTY

Name of Employee. ______________________

Item No. ________

Period

From ______________ to ______________
(Inclusive)

Total No. of Hours ________

Days to Be Charged to

Vacation	________	Leave Without Pay	________
Personal Leave	________	Leave With 1/2 Pay	________
Pass Days	________	Other Leave	________
Sick Leave	________	(Explain Below)	

Comments (Where Required—Enter Reason for Request. Explain "Other Leave")

Date ________ Title ______________________ Signature ______________________

☐ Approved
☐ Disapproved
Date ______________

DIRECTOR

☐ Approved
☐ Disapproved
Date ______________

SUPERVISOR OR DEPARTMENT HEAD