NAME | DATE

ORGANIZATIONAL UNIT

STANDING ROCK SIOUX TRIBE

TYPE OF LEAVE ☐ ANNUAL ☐ WITHOUT PAY ☐
☐ SICK* ☐ COMPENSATORY

BEGIN *(Month, date, and hour)*	☐ A.M. ☐ P.M.	END *(Month, date, and hour)*	☐ A.M. ☐ P.M.	NO. HOURS

NOTE – Annual leave authorized in excess of that to your credit will be charged to leave without pay.

*I certify that this absence was due to:

☐ illness which incapacitated me for duty, or

☐ medical, dental, or optical treatment by _____
(Name of practitioner)

(If absence was in excess of 3 days, request your doctor to fill in the medical certificate on the back of this Standard Form 71: otherwise state under "Remarks" why the certificate was not obtained.)

SIGNATURE OF APPROVING OFFICER | SIGNATURE OF EMPLOYEE

APPLICATION FOR LEAVE

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