EMPLOYEE REQUEST FOR REINSTATEMENT OF VACATION LEAVE DUE TO DISABILITY

Employee Name: _____ **Position:** _____

Employee number: _____ **Date of Request**: _____

1. Please describe the reason for your request? (Confidential Medical details not required)

_____

_____

Include:

Week(s) Requested:_____ to _____Yr _____

Dates of Illness:_____ to _____ Yr _____

Employee's Signature: _____ Date: _____

2. Employee Health & Wellness Unit

☐ Recommended

☐ Not Recommended

X Medical Certificate Received

Date:_____

Comment:

_____

_____

_____

EHW's Name: _____ Signature: _____

Date: _____

3. TFFM Management

☐ Approved

☐ Not Approved

Comment:

_____

_____

Approver's Name:_____ Signature : _____

Date: _____

cc : **Employee File and Payroll**