FAZAIA COLLEGE OF NURSING AND ALLIED HEALTH SCIENCES
AIR UNIVERSITY

LEAVE APPLICATION FORM (FACULTY)

(Filling of all column is mandatory)

Name: _____ **Date:** _____

Designation: _____ **Department:** _____

Leave requested from _____ **to** _____ **Number of Days:** _____

Leave Type: Casual ☐ Annual ☐ Medical ☐ Other _____

Reasons for Current Leave _____

Date: Applicant Signature

Duties will be performed by (Relieving Faculty): _____

Date: Signature & Seal

Remarks by the HOD:

Recommended / Not Recommended

Date: Signature & Seal

Remarks by the Principal (FCoNAHS):

Recommended / Not Recommended

Date: Signature & Seal

Remarks by HR Department:

Entitled / Not Entitled

Date: Signature & Seal

Remarks by the Dean Faculty of Health Sciences:

Approved / Not Approved

Date: Signature & Seal

Note: Please submit the approved application form to HR Department for record in Biometric as well.

FCoNAHS		HR-FMC	
Leaves Availed		Leaves Availed	
Leaves Balance		Leaves Balance	
Leaves Requested		Leaves Requested	
Leaves Category		Leaves Category	
Initiated by		Verified by	
Date & Signature		Date & Signature	

Note (If Any):-

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