



FAZAIA COLLEGE OF NURSING AND ALLIED HEALTH SCIENCES AIR UNIVERSITY

LEAVE APPLICATION FORM (STAFF)

(Filling of all column is mandatory)

Name: _____ Date: _____

Position: _____ 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 (Reliever Name): _____

Date: _____ Signature & Seal _____

Remarks by the HOD:

Recommended / Not Recommended

Date: _____ Signature & Seal _____

Remarks by the Principal FCoNAHS:

(Principal can approve casual leave upto 04 Days and recommend the remaining)

Approved / Not Approved

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):-
