

REPLACEMENT LEAVE FORM

Name of Staff _____

Unit / Head of Unit _____

Applicable only to work done on Off days/Sundays/Public Holidays

Date	Hours Worked (please tick)		Brief Description of Work
	0-4 hrs	>4 hrs	
TOTAL ** (DAYS)			

** 0-4 hrs – ½ day
 >4 hrs – 1 day

Total number of days to be replaced _____

Signature of Staff _____

Approved by _____ (Head of Unit)

TO BE COMPLETED BY HR DEPT ONLY

No. of days credited into annual leave _____ Balance of leave now _____

Record updated on _____ Recorded by _____