

# FAX

**To:** Mary Bird and Jeff Robert

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**CC:**

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**Date:** October 27, 2015

**Fax:** 807-622-3024

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**Re:** Request for Leave Record

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**From:** Don Sainnawap

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**Phone:** 737-3592

**Fax:**

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**# of Pages including cover:** 3

Urgent

For Review

Please Reply

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**Comments:**

Please see attachments.

Thank You!



*Mary Bird / Jeff Kober*

**NISHNAWBE-ASKI LEGAL SERVICES CORPORATION**

**REQUEST FOR LEAVE RECORD**

Date: Oct 26 2015

Name of Employee: Don Sacunawap

Position: CUW

Supervisor: Mary Bird

Please provide copies as follows:

- 1 copy - Employee
- 1 copy - Finance/HR
- 1 copy - Supervisor

Form required 3 days in advance for V, M, D, C, J, W

Number of Hours: \_\_\_\_\_

Number of Days: \_\_\_\_\_

From (ddmmyy): Oct 25/15

To (ddmmyy): Nov 25/15

If sick leave - medical certificate provided Y or N? \_\_\_\_\_

<u>Type of Leave</u>	
Please checkmark one.	
<input type="checkbox"/> Bereavement (B)	If J, B, C, L, M - Reason given:  <i>see attached note</i>
<input type="checkbox"/> Compassionate (C)	
<input type="checkbox"/> Lieu Time (L)	
<input type="checkbox"/> Court (J)	
<input type="checkbox"/> Marriage (W)	
<input checked="" type="checkbox"/> Sick (S)	
<input type="checkbox"/> Management (M)	
<input type="checkbox"/> Vacation (V)	

If Leave is Without Pay (Check Here) \_\_\_\_\_

Employee's Signature Don Sacunawap

Supervisor's Signature Mary Bird

Date Oct 26/15

Date 27 Oct 15

Executive Director Approval  
(Required for M, C, B Leave)

Date: \_\_\_\_\_

Sioux Lookout Meno Ya Win Health Centre

P.O. Box 909  
Sioux Lookout, ON P8T 1B4  
Telephone: (807) 737-3030

FOR WON SHAWAH RIN

ADDRESS \_\_\_\_\_

**R<sub>x</sub>**

DATE OCT 26 2015

PLEASE EXCISE IT  
FROM WORK ACTIVITIES  
FROM OCT 25 - NOV 25  
(INCLUSIVE) DUE TO MEDICAL  
REASON

REPEAT \_\_\_\_\_ TIMES

\_\_\_\_\_ DAYS APART

DO NOT REPEAT



MD