

VACRF *ae*
entered for 7/29-8/9

State of Ohio
Request For Leave

Name (Last) Emrich (First) Lisa (Middle Initial) G. Date 7/17/13
Employing Unit _____

I request leave Beginning 8⁰⁰ (time) A.M. P.M. 7/17/13 (date), 2013 (year), and
Ending 5⁰⁰ (time) A.M. P.M. 7/26/13 (date), 2013 (year), for the following reason:

Mark Appropriate Boxes Below:

- Sick Leave # of Hours _____ (Explain _____)
- Vacation # of Hours 80 Personal # of Hours _____ Compensatory # of Hours 80 *ae*
- Leave Without Pay (Explain _____)
- Bereavement Name of Deceased _____ Relationship _____ Date of death _____
- (Attach copy of subpoena or summons)
- Jury Duty Witness Duty
- (Attach copy of orders, or other appropriate documentation, that supports request for Military leave)
- Military With Pay Military Without Pay
- Adoption / Childbirth Leave Event Date _____ Do you wish to supplement? Yes No
- Pending Disability Pending Workers' Compensation Do you wish to supplement? Yes No
- Other (Explain _____) this absence due to a condition for which an FMLA certification form is on file? Yes No **Total Hours Requested** _____

I have insufficient sick leave for the above request. I request the following in lieu of sick leave:
 Vacation Personal
 Compensatory Leave Without Pay

I certify that this request for leave form contains true and complete information.
Lisa G. Emrich
Signature of Employee

Administrative Action

<input type="checkbox"/> Recommended <input checked="" type="checkbox"/> Not Recommended	<input type="checkbox"/> Approved <input checked="" type="checkbox"/> Disapproved
Supervisor Signature <u>[Signature]</u> Date <u>7-17-13</u>	Appointing Authority Signature <u>[Signature]</u> Date <u>7-17-13</u>
Remarks _____	Remarks _____

Exhibit 4

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State of Ohio

Request For Leave

Name (Last)	(First)	(Middle Initial)	Date
Emrich	Lisa	G	5/28/14
Employing Unit Nursing Board			
I request leave			
Beginning (time)	<input checked="" type="checkbox"/> A.M. <input type="checkbox"/> P.M.	June 2	2014
Ending (time)	<input type="checkbox"/> A.M. <input checked="" type="checkbox"/> P.M.	June 13	2014
, and for the following reason:			

Mark Appropriate Boxes Below:

<input type="checkbox"/> Sick Leave # of Hours _____ (Explain)			
<input checked="" type="checkbox"/> Vacation # of Hours 80	<input type="checkbox"/> Personal # of Hours _____	<input type="checkbox"/> Compensatory # of Hours _____	
<input type="checkbox"/> Leave Without Pay (Explain)			
<input type="checkbox"/> Bereavement	Name of Deceased	Relationship	Date of death
(Attach copy of subpoena or summons)			
<input type="checkbox"/> Jury Duty	<input type="checkbox"/> Witness Duty		
(Attach copy of orders, or other appropriate documentation, that supports request for Military leave)			
<input type="checkbox"/> Military With Pay	<input type="checkbox"/> Military Without Pay		
<input type="checkbox"/> Adoption / Childbirth Leave	Event Date	Do you wish to supplement? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Pending Disability	<input type="checkbox"/> Pending Workers' Compensation	Do you wish to supplement? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Other (Explain)	Is this absence due to a condition for which an FMLA Certification form is on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Hours Requested	

I have insufficient sick leave for the above request. I request the following in lieu of sick leave:

<input type="checkbox"/> Vacation	<input type="checkbox"/> Personal
<input type="checkbox"/> Compensatory	<input type="checkbox"/> Leave Without Pay

I certify that this request for leave form contains true and complete information.

Lisa Emrich
Signature of Employee

Administrative Action

<input type="checkbox"/> Recommended	<input checked="" type="checkbox"/> Not Recommended	<input type="checkbox"/> Approved	<input checked="" type="checkbox"/> Disapproved
Supervisor Signature	Date	Appointing Authority Signature	Date
Remarks <i>[Signature]</i>		Remarks	

State of Ohio
Request For Leave

Name (Last) **Emrich** (First) **Lisa** (Middle Initial) **G** Date **12/29/2014**

Employing Unit **Nursing Board**

I request leave
Beginning 0800 A.M. P.M. January 26, 2015, and
Ending 17:00 A.M. P.M. February 6, 2015, for the following reason:

Mark Appropriate Boxes Below:

Sick Leave # of Hours _____ (Explain)
 Vacation # of Hours 80.0 Personal # of Hours _____ Compensatory # of Hours _____
 Leave Without Pay (Explain)
 Bereavement Name of Deceased _____ Relationship _____ Date of death _____

(Attach copy of subpoena or summons)
 Jury Duty Witness Duty

(Attach copy of orders, or other appropriate documentation, that supports request for Military leave)
 Military With Pay Military Without Pay

Adoption / Childbirth Leave Event Date _____ Do you wish to supplement? Yes No

Pending Disability Pending Workers' Compensation Do you wish to supplement? Yes No

Other (Explain) _____ Is this absence due to a condition for which an FMLA Certification form is on file? Yes No Total Hours Requested _____

I have insufficient sick leave for the above request. I request the following in lieu of sick leave:
 Vacation Personal
 Compensatory Leave Without Pay
I certify that this request for leave form contains true and complete information.
Lisa J Emrich
Signature of Employee

Administrative Action

Recommended Not Recommended Approved Disapproved

Supervisor Signature *[Signature]* Date 12-29-14 Appointing Authority Signature *[Signature]* Date 12-29-14

Remarks _____ Remarks _____