



**RAI MEDICAL COLLEGE SARGODHA  
DOCTOR'S TRUST TEACHING HOSPITAL**

**EMPLOYEE LEAVE FORM**

CASUAL     SHORT     STATION     MEDICAL     EARNED     UNPAID

Name: \_\_\_\_\_

Designation: \_\_\_\_\_

Department: \_\_\_\_\_

Period    From: \_\_\_\_\_    To: \_\_\_\_\_

No of Day's \_\_\_\_\_    Balance \_\_\_\_\_

Reason for Leave: \_\_\_\_\_

Address While on leave: \_\_\_\_\_

Contact No: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

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

Reliving: \_\_\_\_\_

Name of Reliever: \_\_\_\_\_

Designation: \_\_\_\_\_

Department: \_\_\_\_\_

Remarks by HOD \_\_\_\_\_ Sign: \_\_\_\_\_

Remarks by MS \_\_\_\_\_ Sign: \_\_\_\_\_

Approved     Not Approved

Vice Principal RMCS

Principal/Chief Executive RMCS

Sign: \_\_\_\_\_

Sign: \_\_\_\_\_