

AG 2



ACN 008 661 901

LEAVE APPLICATION / ABSENCE REPORT

INSTRUCTIONS

- Prepare form in triplicate
- Forward all copies to the Authorising Officer for signature
- Authorising Officer forwards original copy directly to appropriate Payroll Officer
- Duplicate retained by Manager / Supervisor
- Triplicate retained by Employee

FULL NAME: MARK PICKERING STAFF No.: 852728 CLOCK No.: _____
 JOB TITLE: RGS SALES SECTION/DEPT: RGSN
 LOCATION: MEL EXT No.: 75 803 HOME No.: _____
 COST CENTRE: (if required) _____ CREW: (if required) _____

TOTAL PERIOD OF ABSENCE

FROM	TIME	DATE	TIME	DATE
	HRS	<u>18/2/04</u>	HRS	<u>17/2/05</u>

Note: Period of absence must include all days off, e.g. for shift workers, include rostered days off

TYPE OF LEAVE (Tick appropriate box)	No. of Days	No. of Hours	(Hours when relevant for shift workers and / or when taking part days)
<input type="checkbox"/> Annual	<input type="checkbox"/>	<input type="checkbox"/>	Is payment in advance required? <input type="checkbox"/> YES
<input type="checkbox"/> Long Service *	<input type="checkbox"/>		If Yes, this application must be submitted 15 working days prior to leave

* LSL is based on calendar days, not working days

<input type="checkbox"/> Twentieth Day	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sick	<input type="checkbox"/>	<input type="checkbox"/>	Supporting Documentation <input type="checkbox"/> YES <input type="checkbox"/> NO (Medical Cert., Stat. Dec. or other e.g. for bereavement show relationship)
<input type="checkbox"/> Carer's Leave *	<input type="checkbox"/>	<input type="checkbox"/>	Nature of illness: _____ Is this Sick Leave related to a Workers' Compensation Claim? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input checked="" type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	Type (of Other Leave): <u>LEAVE WITHOUT PAY</u> (e.g. Days in lieu, Defence, etc) Please attach documentation)

* Please indicate whether to be allocated against Sick or Annual Leave

* Please indicate type of Leave opposite

NB: Understand the Company's policy that if unfit for duty, staff must not avail themselves of concessional staff travel without the prior approval of the departmental General Manager, clearance from a Company Doctor or Company nominated Medical Officer and, where necessary, the General Manager Occupational Health & Safety. Breach of this policy will result in disciplinary action being taken

EMPLOYEES' SIGNATURE: M Pickering DATE: 12/2/04

AUTHORISED BY: (e.g. Supervisor / Manager or other authorised officer when supervisor not authorised)
Note: For E&M staff, EMCOST approval is also required.

NAME: Simon Bernardi TITLE: HOQA DATE: 17.2.04

SIGNATURE: _____ DATE: _____

COUNTER SIGNATURE: (if required) _____ DATE: _____

PAYROLL DEPARTMENT USE

RECEIVED: _____ ACTIONED: _____ BY: _____

Printed in Australia

12.2.04

I MARK PICKERING WOULD LIKE TO
APPLY FOR LEAVE WITHOUT PAY FOR A
PERIOD OF 6-12 MONTHS ON COMPASSIONATE
GROUNDS. I WILL BE THE PRIMARY CARER
FOR MY TERMINALLY ILL MOTHER WHO
REQUIRES FULL TIME NURSING CARE + SUPERVISION.

SHE IS IN PALLIATIVE CARE, DUE TO
END STAGED LIVER FAILURE AND HAS
BEEN GIVEN 6-12 MONTHS.

I CAN PROVIDE MEDICAL EVIDENCE TO THIS
AFFECT IF NEEDED.

YOUR ASSISTANCE IN THIS PERSONAL MATTER
WOULD BE GREATLY APPRECIATED.

SIGNED

M. Pickering