IDEAL INSTITUTE OF NURSING, KALYANI SHILPANCHAL

LEAVE APPLICATION FOR FACULTY/STAFF

Name of the applicant:_____ **Designation:**_____

Type of leave:_____

Period of leave: From_____ **to** _____

Reason of leave:_____

Mobile No:_____

Address:_____

Class replacement:

1._____

Class replaced **Replacing Teacher's name** **Sign of Teacher**

Date:_____

_____
Sign of applicant

Leave status:_____**(Allowed/Not Allowed)**

Sign of CEO **Sign of the Principal / Sign of the Vice Principal**

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