

FORM OF APPLICATION FOR LEAVE

NOTE:- Items 1 to 10 must be filled in by all applicants irrespective of Gazetted or Non-Gazetted.

1	Name of Applicant	:	
2	Leave Rules Applicable	:	
3	Post held	:	
4	Department, Office and Section	:	
5	Pay.	:	
6	HRA / CA or other compensatory allowances drawn in the present post	:	
7	Nature and period of leave applied for and date from which required	:	
8	Sundays and holidays, if any, proposed to be prefixed / Suffixed to leave.	:	
9	Ground on which leave is applied for.	:	
10	Date of return from last leave, and the nature and period of that leave		
11	(a)	I undertake to refund the difference between the leave salary drawn during leave on average pay and that admissible during leave on half average pay which would not have been admissible had the proviso to F.R. 81 (b) (ii) not been applied in the event of my retirement from service at the end or during the currency of the leave.	
	(b)	I undertake to return the leave salary drawn during “ leave not due” which would not have been applied, in the event of my voluntary retirement from service at the end or during the currency of the leave.	

Signature of the applicant
with date:

12 Remarks and / or recommendations :
of the Controlling Officer.

Signature (with date)
Designation

>>> P.T.O.

CERTIFICATE REGARDING ADMISSIBILITY OF LEAVE

13 Certified that (_____) for (_____)
from (_____) to (_____) is admissible
under rule _____ of the
_____-Rules.

Signature (with date)
Designation

14 Orders of the sanctioning authority

Signature (with date)
Designation

FORM - A

MEDICAL CERTIFICATE

Name	:	
Appointment	:	
Age	:	
Total Service	:	
Previous residents of leave of absence on Medical Certificate	:	
Habits	:	
Disease	:	
History	:	

I _____ of _____, Regd. Medical Practitioner No. _____ After careful personal examination of the case hereby certify that _____ is in a bed state of health and I solemnly and affirm declare that according the best of my judgment a period of absence from duty is essentially necessary for the recovery of His / Her health and recommended that He / She may be granted _____ months leave with effect from _____ to _____.

Doctor’s Signature

FORM - A
MEDICAL CERTIFICATE

Signature of Applicant :

Registered Medical Practitioner

I _____ do hereby certify
that I have examined ABC of _____
_____ whose signature is given above
and found that he has recovered from the illness and is now fit to resume duties in
Government Service. I also certify that before arriving at this decision. I have
examined the Original Certificates and Statements of the case on which I have granted
or attended and taken as in to consideration at arriving at my decision.

Doctor's Signature with seal