

RNUNL UNPAID LEAVE CLAIM

NAME _____ SOCIAL INSURANCE NUMBER _____

MAILING ADDRESS _____

POSTAL CODE _____ PHONE (HOME) _____ (WORK) _____

EMAIL _____ NS _____ STEP _____ HOURLY RATE _____

PURPOSE OF EXPENSE _____

DATE							TOTAL HOURS
HOURS OF UNPAID LEAVE BEING CLAIMED							
DAY / EVENING / NIGHT (D ₈ , D ₁₂ , E, N ₈ , N ₁₂)							
NO. OF HOURS SHIFT / WEEKEND / IN CHARGE							
EDUCATIONAL ALLOWANCE							
LABRADOR ALLOWANCE							
OTHER (Specify with rate) RATE:							

This section must be completed by your supervisor or an appropriate employer representative.

This is to provide verification that _____

has been granted _____ hours of unpaid leave for the dates

Signature _____ Position _____

Date _____

I request payment as detailed above.

Member Signature _____ Date _____

***INCOMPLETE OR IMPORPERLY COMPLETED CLAIMS WILL BE RETURNED TO THE MEMBER FOR PROPER COMPLETION BEFORE THE CLAIM IS PROCESSED.**