# Claim for Payment of Lost Excess Annual Leave

**To Be Completed By the Employee:**

_____ _____ _____
Name (PRINTED) State Employee ID # Facility/Unit

My signature certifies that I am requesting payment for excess annual leave hours that were lost due to the denial of a request for annual leave or the facility/unit's cancellation of a previously approved request. It is my understanding that such denial or cancellation occurred and I was required to be at work as my absence could pose a threat to public safety, health or welfare.

_____ _____
Signature Date

**To Be Completed By the HRMS:**

My signature certifies the following:

The employee's request for annual leave for the period of time beginning: _____ and ending: _____ was denied or cancelled; **and**

The excess annual leave was lost as a result of the employee working during the specified period of time; **and**

The annual leave hours were removed from the employee's leave balance at the close of the pay period which corresponds with the beginning or ending dates of the requested leave time.

# of excess annual leave hours lost: _____ (Attach copy of Employee Leave Accrual Report)

_____ _____
Signature of HRMS Date

**To Be Completed By the Facility/Unit Head:**

My signature certifies that a request for annual leave for the above referenced time period was denied or cancelled and the employee was required to be at work during that time period as his/her absence could have posed a threat to public safety, health or welfare.

_____ _____
Signature of Facility/Unit Head Date

_____ _____
Signature of Administrator/Chief Administrator Date

Distribution/Approved Claims: Original to Central Human Resources unit Copy to Employee Copy to file
Denied Claims: Original to file Copy to Employee

(R 08/21)