

EMPLOYEE FUNDED LEAVE PROGRAM PROGRAM CANCELLATION

EMPLOYEE INFORMATION

Name _____ Social Insurance Number
last name first name initial

Address _____
suite no. street/box no.

city province postal code

For Office Use Only.
Employee Number
Department
Birthdate
Y / M / D Gender

CANCELLATION

I wish to withdraw from this program effective _____. My reasons are as follows:

I declare that the above information is true.

(Date) (Employee's Signature)

DEPARTMENTAL APPROVAL

Approval for this employee to withdraw from this program is _____ (given/denied).

(Date) (Deputy Minister or Chief Executive Officer)

CANCELLATION – NON-VOLUNTARY

Effective _____ the above mentioned employee is no longer participating in this program for the following reason _____.

(Date) (Deputy Minister or Chief Executive Officer)