COLLEGE of CHARLESTON

HUMAN RESOURCES

ADVANCED SICK LEAVE REQUEST FORM

Employee Name:___________________________________

Department: ____________________________________

Date: ____________________________________

Reason for the request of up to 15 days of advance sick leave *______________________________________

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Departmental Approval____________________________________ Date: _______________________

Departmental Disapproval _________________________________ Date: _______________________

Human Resources Approval ________________________________ Date: _______________________

Human Resources Disapproval ______________________________ Date: _______________________

Please return this form to Human Resources after departmental signature is obtained.

* Provide medical documentation supporting the advanced sick leave request.