

REQUEST FOR LEAVE

NAME _____ College of Charleston ID# (CWID#) _____
 DEPARTMENT _____

Permission is requested to take leave on the date(s) listed below.

Date	Beginning at (hour/minute)	Ending on (hour/minute)	Total Hours Requested	Leave Code No.	Remarks

Leave Code No.

1. Annual Leave
2. Personal Sick Leave/Medical Appt.*
 __three or less days __over three days
3. Family Sick Leave/Medical Appt.*
 __three or less days __over three days
4. Birth of Child*
5. Adoption/Foster Care**
6. Leave Without Pay

Leave Code No.

7. Voting Leave
8. Military Leave***
 __15 days or less __over 15 days
9. Death in Family
 Relation: _____
10. Court Leave***
11. Compensatory Leave
12. Other _____

Does This Leave Qualify Under the Family and Medical Leave Act (FMLA) Yes __ No__

Employee Signature _____ Date _____

Departmental Approval _____ Date _____

Please use this form for all leave requests.

*May require medical certification; send copy of leave request form to Human Resources.

**May require legal papers; send copy of leave request form to Human Resources.

***Court Summons/military orders required; send copy of summons/orders to Human Resources.

Send copy of request form to Human Resources when leave qualifies under FMLA.

Sick Family Leave – up to 10 days/calendar year

Immediate family includes spouse, children, mother, father, sister, brother, grandparents, legal guardian and grandchildren (when the grandchild resides with the employee and the employee is the primary caretaker of the grandchild) of either the employee or the spouse.

Death in the Immediate Family – up to three consecutive workdays with pay for death of spouse, parents, grandparents, great-grandparents, brothers, sisters, children, grandchildren and great-grandchildren of either the employee or the spouse.