COLLEGE of CHARLESTON

HUMAN RESOURCES

ADVANCED SICK LEAVE REQUEST FORM

Employee Name:_____

Department: _____

Date: _____

Reason for the request of up to 15 days of advanced sick leave*:

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.

TO: Director of Human Resources

SUBJECT: Advanced Sick Leave Attestation

This is to confirm that I understand that as a result of my being awarded up to 15 days of advanced sick leave, I am not allowed to use any additional accrued sick leave until the advanced hours have been paid back to the College of Charleston. In addition, I understand that, upon my return to work, I will have all future earned sick leave withheld to reduce the leave deficit at the rate of 1.25 days per month (or if part-time, the monthly earning rate) until the deficit has been reimbursed.

I further acknowledge that if my employment with the College ends, for any reason, prior to the advanced sick leave being restored, I will be responsible for reimbursing the College at the time of separation for the balance of any remaining sick leave advanced to me. This may include the College withholding the balance due from my final paycheck. I also understand that, according to SC Human Resources Regulations, if I separate from employment, for any reason, before satisfying the leave deficit and later return to state employment, the leave deficit will need to be satisfied upon reemployment.

_____ _____

Employee Signature Date