Request for Leave

Employee Name: _____
Mailing Address: _____
Social Security Number: _____ **Date of Request**: _____

Reason for Leave

Employee's Own Illness:____
Ill Family Member (Relationship):_____
Personal Leave:____
Maternity:____
Care for New Child:____
Military Leave:____

Time

Start Date: _____
Return Date:_____

Employee's Request on How to Be Paid

Sick Time:_____
Vacation Time:_____
No Pay:_____
Personal Time:_____
Sick Bank Time:_____
Maternity or New Parent : _____

Comments:
_____
_____
_____

Employee's Signature: _____ **Date:** _____

Supervisor's Signature: _____ **Date:** _____

Approval by Human Resources Office_____ **Date:** _____

HR and Payroll Use Only:

Required Medical Documentation
Date Supplied: _____ **Will Supply: _____**

Employee's Accumulated Time Off

Sick Time: _____
Vacation Time: _____
Personal Time: _____
Other: _____

Benefit Continuation

	Yes	No	Cost to Employee per Month
Vacation	_____	_____	_____
Health Plan	_____	_____	_____
Life Insurance	_____	_____	_____
Long Term Disability	_____	_____	_____
TIAA/CREF (RA)	_____	_____	_____
TIAA/CREF (SRA)	_____	_____	_____

cc: Payroll and Benefits Manager
Employee