



MEDICAL UNIVERSITY OF SOUTH CAROLINA

REQUEST FOR LEAVE

Last Name

First Name

M.I.

Type Leave Requested: check appropriate box(es). **USE A SEPARATE FORM FOR EACH ABSENCE**

Supplemental Leave Court* Optional Holiday* : _____ Worked on Holiday* : _____ Military * _____ Date of Holiday _____ Administrative (Assaulted by a patient/client)* Bone Marrow Donor** Blood Donation** Voting Death in Family: _____ Name of Deceased _____ Date and Place of Death _____ Relationship	Annual Leave Is this Family Medical Leave? Yes / <input checked="" type="radio"/> No Vacation _____ Illness _____ Other - Please explain: _____ _____ _____ _____	Leave Without Pay Is this Family Medical Leave? Yes / No Child Birth** Personal Illness/Accident** Illness in Family** Relationship: _____ Other** - Please explain: _____ _____ _____ _____	Sick Leave Is this Family Medical Leave? Yes / No Child Birth** Placement for: <input type="checkbox"/> Adoption** <input type="checkbox"/> Foster Care** Medical Appointments Personal (Illness/Accident) <input type="checkbox"/> 3 days or less <input type="checkbox"/> more than 3 days** Illness in Family** <input type="checkbox"/> 3 days or less <input type="checkbox"/> more than 3 days** Relationship: _____
AMOUNT OF ADMIN. LEAVE REQUESTED: ____ . ____ HRS.	AMOUNT OF ANNUAL LEAVE REQUESTED: ____ . ____ HRS.	AMOUNT OF LEAVE WITHOUT PAY REQUESTED: ____ . ____ HRS.	AMOUNT OF SICK LEAVE REQUESTED: ____ . ____ HRS.
DATE(S): FROM _____ TO _____ TIME(S): FROM _____ AM/PM TO _____ AM/PM	DATE(S): FROM _____ TO _____ TIME(S): FROM _____ AM/PM TO _____ AM/PM	DATE(S): FROM _____ TO _____ TIME(S): FROM _____ AM/PM TO _____ AM/PM	DATE(S): FROM _____ TO _____ TIME(S): FROM _____ AM/PM TO _____ AM/PM

*Requires supporting documentation

**May require administrative approval and/or medical certification

EMPLOYEE SIGNATURE: _____ DATE: _____ SUPERVISOR APPROVAL: _____ DATE: _____

(USE THIS SECTION FOR FAMILY MEDICAL LEAVE ACT (FMLA) APPROVALS ONLY)

I hereby certify that the above named employee meets the requirements for FMLA and that this leave is approved.	
Department Head Signature: _____	DATE
HRM Approval _____	DATE

FOR DEPARTMENT USE ONLY: FOR PAYROLL & LEAVE RECORD KEEPING

DATE LEAVE RECORDED: _____ LEAVE TYPE: ANNUAL SICK ADMIN. INITIALS: _____