

MEDICAL UNIVERSITY OF SOUTH CAROLINA

REQUEST FOR LEAVE

La	st Name	First Name	M .I.
Type Leave Requested: check appropriate box(es)	. USE A SEPARATE FORM FOR EACH ABSEN	NCE	
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? Vacation Illness	Leave Without Pay Is this Family Medical Leave? Child Birth** Personal Illness/Accident** Illness in Family** Relationship:	Sick Leave Is this Family Medical Leave? Child Birth** Placement for: Adoption** Poster Care** Medical Appointments Personal (Illness/Accident) 3 days or less more than 3 days** Illness in Family** 3 days or less more than 3 days** Relationship:
AMOUNT OF ADMIN. LEAVE REQUESTED: HRS. DATE(S): FROM TO TIME(S): FROM TO	AMOUNT OF ANNUAL LEAVE REQUESTED: HRS. DATE(S): FROM TO TIME(S): FROM TO	AMOUNT OF LEAVE WITHOUT PAY REQUESTED: HRS. DATE(S): FROM TO TIME(S): FROM TO	AMOUNT OF SICK LEAVE REQUESTED: HRS. DATE(S): FROM TO TIME(S): FROM TO
*Requires supporting documentation	**May require administrative approval and/or med	dical certification	•
EMPLOYEE SIGNATURE:	DATE:	_ SUPERVISOR APPROVAL:	DATE:
(USE THIS SECTION FOR FAMILY MEDICAL I	EAVE ACT (FMLA) APPROVALS ONLY)		
I hereby certify that the above name	d employee meets the requirements for FMLA	and that this leave is approved.	
Department Head Signature:		DATE	
HRM Approval		DATE	
FOR DEPARTMENT USE ONLY: FOR PAYROL	L & LEAVE RECORD KEEPING		
DATE LEAVE RECORDED:	LEAVE TYPE: ANNU	IAL SICK ADMIN. INITIALS:	