MEDICAL UNIVERSITY OF SOUTH CAROLINA



REQUEST FOR LEAVE

UF SUUTH GARULINA			
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 / 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: Adoption** Foster 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.	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): FROMAM/PM TOAM/PM	DATE(S): FROM TO TIME(S): FROMAM/PM TOAM/PM	DATE(S): FROM TO TIME(S): FROMAM/PM TOAM/PM	DATE(S): FROM TO TIME(S): FROMAM/PM TOAM/PM
*Requires supporting documentation **May require administrative approval and/or medical certification			
EMPLOYEE SIGNATURE:	DATE: S	UPERVISOR APPROVAL:	DATE:
(USE THIS SECTION FOR FAMILY MEDICAL LI	EAVE 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	HRM Approval DATE		
FOR DEPARTMENT USE ONLY: FOR PAYROLL	& LEAVE RECORD KEEPING		
DATE LEAVE RECORDED:	LEAVE TYPE: ANNUAL	SICK ADMIN. INITIALS:	