

# SOUTH LOUISIANA COMMUNITY COLLEGE APPLICATION FOR LEAVE

\_\_\_\_\_  
Employee's Name

\_\_\_\_\_  
Title

I request \_\_\_\_\_ hours of leave from \_\_\_\_\_  
Time      Date      to      \_\_\_\_\_  
Time      Date

- |                                  |   |                                       |                                   |  |   |                                |
|----------------------------------|---|---------------------------------------|-----------------------------------|--|---|--------------------------------|
| <input type="checkbox"/> Annual  | <input type="checkbox"/> Sick                       | <input type="checkbox"/> Compensatory | <input type="checkbox"/> Military | <input type="checkbox"/> Leave without pay | <input type="checkbox"/> Civil, emergency, or special | <input type="checkbox"/> Other |
| <input type="checkbox"/> Regular | <input type="checkbox"/> Illness                    |                                       | (Attach<br>Military<br>Order)     | <input type="checkbox"/> FMLA*             | (Explain below)                                       | (Explain below)                |
| <input type="checkbox"/> FMLA*   | <input type="checkbox"/> Job Related Injury         |                                       |                                   |  |   |                                |
|                                  | <input type="checkbox"/> Medical, Dental or Optical |                                       |                                   |  |   |                                |
|                                  | <input type="checkbox"/> FMLA*                      |                                       |                                   |  |   |                                |
|                                  | <input type="checkbox"/> Non Job Related Injury     |                                       |                                   |  |   |                                |

**Remarks:**

My signature certifies that my absence from duty was for the reason noted above and in the event that I will/have exhaust(ed) all accumulated sick leave. I am requesting that *my accumulated annual leave be charged for any difference in hours (not applicable for Faculty on nine- or ten-month appointment or for persons on FMLA leave).*

Date	Employee's Signature	Employee Status		
		Classified	Unclassified	Faculty

Approved by \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

\*FMLA – leave taken in accordance with the Family & Medical Leave Act of 1993. Request for Family or Medical Leave form must be completed and approved prior to use of FMLA leave. \*\*Written statement from physician may be required by supervisor for three or more consecutive days of sick leave used. *Original to Business Office; copy to employee; copy to Dean.*