SOUTH LOUISIANA COMMUNITY COLLEGE
APPLICATION FOR LEAVE

Employee's Name _____ Title _____

I request _____ hours of leave from _____ (Time) _____ (Date) to _____ (Time) _____ (Date)

- ☐ Annual
  - ☐ Regular
  - ☐ FMLA*
- ☐ Sick
  - ☐ Illness
  - ☐ Job Related Injury
  - ☐ Medical, Dental or Optical
  - ☐ FMLA*
  - ☐ Non Job Related Injury
- ☐ Compensatory
- ☐ Military (Attach Military Order)
- ☐ Leave without pay
  - ☐ FMLA*
- ☐ Civil, emergency, or special (Explain below)
- ☐ Other (Explain below)

_____

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*.