

Please complete the following information and return to your supervisor PRIOR to your leave.

Employee's Name _____
(Please Print)

Date of Request ___/___/___

For FMLA and LWOP only: Do you have CCS health insurance? Yes No

Personal Leave (Paid Time)

From: ___/___/___ (Date) To: ___/___/___ (Date returning to work)

Leave Without Pay* (LWOP)

Reason for request _____

From: ___/___/___ (Date) To: ___/___/___ (Date returning to work)

**LWOP for 20 days or longer needs to be approved by the Program Director and the Executive Director. Benefits will remain in effect until the last day of the month in which the employee was paid.*

Bereavement Leave

From: ___/___/___ (Date) To: ___/___/___ (Date returning to work)

Family Medical Leave (FMLA)

From: ___/___/___ (Date) To: ___/___/___ (Date returning to work)

Employee Signature _____

Date _____

Leave Approved Yes No

Supervisor Signature _____

Date _____

HR Copy Payroll Copy