**LEAVE OF ABSENCE REQUEST FORM**

***Employees requiring a leave of absence or reduced schedule for medical reasons for themselves or for a qualifying family member, pregnancy disability leave or for parental leave for the purpose of bonding with a newborn, adopted child or foster care placement may qualify for protected leaves. To see if you qualify, please return this form to the Human Resources Office in person, by campus mail, or email your form to*** [***benefits@pierce.ctc.edu***](mailto:benefits@pierce.ctc.edu)***. Employees will receive an eligibility letter outlining qualifying leave types and any required verification and/or supporting documentation needed to process the leave request.***

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| **Section 1 – Completed by Employee** | | | | | | |
| Employee’s Last Name, First, MI: (Please Print) | | | Division/Department: | | | EID |
| Employee Type: ☐ Classified ☐ Administrative Exempt  ☐ Full Time Faculty ☐ Part Time Faculty | | | Do you work in multiple positions at Pierce College? ☐ Yes ☐ No  If yes, please list: | | | |
| This request is not in conjunction with Shared Leave nor Workers Compensation.  As an Exempt employee, I elect to **exhaust** my accrued sick leave and vacation leave **before FMLA begins**.   * For parental leave, employee exhausts all paid leave except sick leave and then begins unpaid FMLA Parental Leave.   As an Exempt employee, I elect to **use** my accrued sick leave and vacation leave **during** FMLA.  As a Faculty employee, I elect to **exhaust** my accrued sick leave **before FMLA**.  As a Faculty employee, I elect to **use** my accrued sick leave **during FMLA**. | | | | | | |
| Reason(s) for Request: ☐ Serious Health Condition (Includes Post-Partum Recovery) ☐ Serious Health Condition of a Family Member ☐ Parental Bonding (Biological, Adoption or Foster Care) ☐ Pregnancy Disability Leave ☐ Military Leave (Family/Caregiver)  ☐ Other (Please Specify): | | | | | | |
| Use this space for additional information/comments related to your request: | | | | | | |
| Requested Leave of Absence | | Leave taken will be:  ☐ Continuous  ☐ Intermittent  ☐ Both | | If intermittent, estimate number of days and duration:  \_\_\_\_\_\_\_\_ days per week/month (circle one)  Duration: \_\_\_\_\_\_\_hours or \_\_\_\_\_\_ day(s) per episode | | |
| From | To |
| If both, continuous leave from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , intermittent leave from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Start Date) (End Date) (Start Date) (End Date) | | | | | | |
| If requesting a reduced schedule, list days/hours: Mon \_\_\_\_\_\_\_\_\_\_ Tue \_\_\_\_\_\_\_\_\_ Wed \_\_\_\_\_\_\_\_\_ Thu \_\_\_\_\_\_\_\_\_ Fri \_\_\_\_\_\_\_\_\_ | | | | | | |
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| **Section 2 – Employee Signature** | | | | | | |
| By my signature below, I certify the information I provided is true, accurate and complete. I also understand that I must provide supporting documentation outlined in an eligibility letter in order for my leave request to be processed by Human Resources. | | | | | | |
| Employee Signature | | | | | Date Signed | |

Date Last Updated: November 5, 2019