



Local Leave Request Form

Employee Name: _____ Date: _____

Employee #: _____ Campus/Location: _____

To be considered for Local Sick Leave you must first meet the following criteria:

- Must be a full-time employee; and
- Leave is requested due to a catastrophic illness or injury of the employee or a member of the employee’s immediate family; and
- Employee has exhausted all available paid benefits including state and local days.

After reading the above, I feel I meet the criteria for Leave for the following reason(s):

[Please explain and attach any paperwork (physician’s note, etc.) that will be helpful in considering your request.]

Number of days you are requesting? _____ (maximum 30 days)

After completing this request for Local Leave, give to your campus principal or supervisor for approval.

Approval signature of principal/supervisor _____

Date _____

In the event that the request is not approved by the principal/supervisor, the reasons for declining the request will be shared with the employee.

Received in business office by _____

Date Received _____