COAHOMA COMMUNITY COLLEGE

EMPLOYEE LEAVE REQUEST

TWO WEEKS OR LONGER

Name_____ Position _____ Date of Request _____

Department_____ Supervisor _____

Date(s) Leave Beginning _____ Ending _____

Type of Leave: (check One)

☐ FMLA
- Maternity ☐
- Adoption ☐
- Spouse, son or daughter, or parent ☐
- Medical Leave ☐

☐ Indefinitely Leave

☐ Personal

☐ Military Leave

☐ Sick Leave ☐ One Week ☐ Two Weeks ☐ One Month or Longer

☐ Worker's Compensation

☐ Educational Leave ☐ 4 to 6 Weeks ☐ 3 to 6 Months or Longer

☐ Leave without Pay ☐ One Week ☐ Two Weeks ☐ One Month or Longer

Was there a written request for leave? _____ If so, please attach. If not, has the employee been notified of the college's leave policy? Yes_____ or No_____ Date Employee Will Return From Leave _____.

Employee _____ Date _____

Dean/Director _____ Date _____

Business Manager_____ Date _____

President _____ Date _____