CRISIS LEAVE REQUEST FORM

Employee Name: ___________________________ Personnel #: __________________________

Position Title: _____________________________ Section Head Name: ___________________

Classification: _____________________________ Section: ______________________________

Number of Crisis Leave Hours Requested: ____

Beginning Date of Illness or Injury: ____

Anticipated Return to Work Date: ____

Detailed Description of Illness or Injury:

Detailed description of the planned uses of crisis leave during the requested period (*i.e., doctor's appointments, treatments, hospitalization, etc.*):

Employees must attached a copy of their Licensed Medical Service Provider (LMSP) statement to this form.

______________________________________ ______________________________

Employee Signature Date

NOTE: Crisis Leave Request Forms must be submitted to the Leave Pool Manager or his designee within the Office of Human Resources.

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For Committee Use Only

CRISIS LEAVE COMMITTEE DECISION

☐ Approved ☐ Denied **Number of Hours Approved:** ____________

The value of the annual leave granted, as crisis leave, will be 75% of the pay you receive in a regularly scheduled workweek.

____ ______________________

Representative Signature Date