

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 _____
