



LEAVE REQUEST FORM

Employee Status: Full-Time Part-Time

Union Status: NBF Local 1708 Local 1600 Local 3506 Local 1220 Local 399 Local 73 IEA-NEA

EMPLOYEE INFORMATION:

Name: _____	Employee ID: _____
College/District Office: _____	Department: _____
Position Title: _____	Home Telephone No.: _____
Job Family: _____	Work Telephone No.: _____

LEAVE INFORMATION

Type Of Leave:		
<input type="checkbox"/> Illness	<input type="checkbox"/> Medical	<input type="checkbox"/> Family and Medical Leave (FMLA)
<input type="checkbox"/> Maternity/Parental (NBF/1600/1708)*	<input type="checkbox"/> Peace Corp	<input type="checkbox"/> The birth and or care of a child*
<input type="checkbox"/> Military Leave	<input type="checkbox"/> Professional	<input type="checkbox"/> Placement of a child with the employee for adoption or foster care*
<input type="checkbox"/> Personal	<input type="checkbox"/> Special	<input type="checkbox"/> To care for a spouse, child, or parent with a serious health conditions
<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Summer	<input type="checkbox"/> Serious health condition of the employee that makes it impossible for him/her to perform the functions of this job.
<input type="checkbox"/> Other _____		
* Newly eligible child(ren) must be reported to CCC Benefits within 31 days from the date of birth or date of adoption/foster care. Refer to: ccc.edu > Human Resources > Benefits > Coverage, Eligibility & Changes for More information.		
Requested Leave: <input type="checkbox"/> Paid <input type="checkbox"/> Unpaid		
Leave Dates: _____ / _____ / _____ to _____ / _____ / _____ <input type="checkbox"/> Intermittent <small>(month) (day) (year) (month) (day) (year)</small>		

Note: Short Term Disability or Long Term Disability benefits may be reduced or offset by any salary continuation from CCC or Workers' Compensation as applicable.

Instructions: Please submit this form to your HR Department or the Benefits Department Leave Management Team. You MUST submit all medical documentation from your health care provider to the Benefits Department Leave Management Team at leavemanagement@ccc.edu within 15 days of submission of this notice request.

Signature of Employee Date

FOR ADMINISTRATIVE USE ONLY: Approved by District Office of Human Resources Yes No

Benefits Department Leave Administrator Date

College President/Vice Chancellor Date

Supervisor/Manager Date

(Signature of Supervisor/Manager does not constitute final Leave approval)

Approve Leave: <input type="checkbox"/> Paid <input type="checkbox"/> Unpaid <input type="checkbox"/> Partially Paid and Partially Unpaid		
Leave Dates: _____ / _____ / _____ to _____ / _____ / _____ <input type="checkbox"/> Intermittent _____ <small>(month) (day) (year) (month) (day) (year)</small> Frequency/Detail		