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SAINT FRANCIS UNIVERSITY
REQUEST TO RECEIVE COMPASSIONATE LEAVE

Employee Name:_____

Employee Last 4 digits SS#_____ Department:_____

A physician's statement of medical certification of the health condition must be provided with this request.

I am requesting donations (up to 12 weeks) to cover future absence(s) for the reason stated in the attached physician's statement. The requested donations will exceed my earned time off, as required by the Compassionate Leave Policy.

This leave will cover the period from _____ to _____.
mm/dd/yyyy **mm/dd/yyyy**

_____ _____
Date **mm/dd/yyyy** *Employee Signature*

HUMAN RESOURCE OFFICE USE ONLY

Request received in HR Office on _____.

_____Recipient is a full-time University employee and has completed at least one year of full time employment.

_____The absences were for the recipient or family member's catastrophic illness/injury.

_____The absences were not due to a work-related illness/injury.

_____Physician medical certification statement has been received.

_____Date when all accrued earned time off will be (or has been) exhausted.

_____APPROVED _____NOT APPROVED -- Reason:_____

_____

_____ _____
Date Director of Human Resources