

**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 _____.

Date

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