Absence Request Form

CATHOLIC COMMUNITY SERVICE

Please complete the following information and return to your supervisor PRIOR to your leave.

Employee's Name _____ Date of Request ___/___/___
(Please Print)

For FMLA and LWOP only: Do you have CCS health insurance? ☐ Yes ☐ No

Personal Leave (Paid Time)

From: ___/___/___ To: ___/___/___
(Date) (Date returning to work)

Leave Without Pay* (LWOP)

Reason for request _____

From: ___/___/___ To: ___/___/___
(Date) (Date returning to work)

**LWOP for 20 days or longer needs to be approved by the Program Director and the Executive Director. Benefits will remain in effect until the last day of the month in which the employee was paid.*

Bereavement Leave

From: ___/___/___ To: ___/___/___
(Date) (Date returning to work)

.

Family Medical Leave (FMLA)

From: ___/___/___ To: ___/___/___
(Date) (Date returning to work)

Employee Signature _____ Date _____

Leave Approved ☐ Yes ☐ No

Supervisor Signature _____ Date _____

☐ HR Copy ☐ Payroll Copy