UNIVERSITY OF SOUTH CAROLINA

Request for Leave Without Pay / Return from Leave Without Pay

To Be Completed by the Department			
Name: (Last, First, Middle)			
USC ID:	Class/Slot:	Title:	
Pos. No.:	Dept. Name:		Dept. No.:

Going on Leave Without Pay

LWOP for over 10 working days must be applied for in advance of the leave being taken. Approval by the Division of HR is required.

Select One: Authorized ☐ Unauthorized ☐ Suspension ☐

Select One: Personal (If selected, must attach letter of explanation) ☐ Illness or Disability ☐

Expected Dates of LWOP: through:

For FMLA qualified illnesses (3 days or more in length), has the Employee Medical Certification form (P-75) – or in the event of a family member's illness, the Family FMLA Certification form – been completed and sent by the physician to the Benefits Office? (See Sick Leave Policy.) Yes ☐ No ☐

Reason for LWOP: Job Related: Yes ☐ No ☐

Is the employee a foreign national? Yes ☐ No ☐ If yes, contact ISFS at ISFS@sc.edu.

Signatures **Dates**

I understand that I am responsible for notifying the Benefits Office (as applicable) within 2 business days of signing this form to discuss options for my insurance coverage during the leave period. I further understand that I am also required to notify the Benefits Office (as applicable) within two days of returning to work date following the leave without pay period to be advised regarding insurance coverage. I understand that if I am a Faculty member, there are certain procedures that may be required by the Provost's Office. I will follow up accordingly to ensure those procedures are followed.

Employee:

If the employee does not sign this form, I will contact the Benefits Office (if applicable) within 2 business day of signing this form to notify of this action and initiate communication to the employee in relation to insurance coverage.

Supervisor:

Approved Disapproved Human Resources:

Return from Leave Without Pay (Over 10 days duration)

Date of Return: Date LWOP Began:

Accounting (Attach additional sheets if more space is needed)

Department	Fund	Obj. Class	Analytical	FV	FSO	C	Percent	Amount

To Be Completed by Division of Human Resources/Payroll

Base Salary:	Supplement:	Total Salary:	
Semi-Amt:	OR: (+ / -)	PB:	Hrs/Week:
SSD:	LBD:		

Signatures

Salary Administration: Date: Payroll: Date:

- For Faculty LWOP, if foreign national is indicated, please forward a copy to International Support for Faculty and Staff.