

COLLEGE *of* CHARLESTON

HUMAN RESOURCES

ADVANCED SICK LEAVE REQUEST FORM

Employee Name: _____

Department: _____

Date: _____

Reason for the request of up to 15 days of advance sick leave * _____

Departmental Approval _____

Date: _____

Departmental Disapproval _____

Date: _____

Human Resources Approval _____

Date: _____

Human Resources Disapproval _____

Date: _____

Please return this form to Human Resources after departmental signature is obtained.

* Provide medical documentation supporting the advanced sick leave request.