CITY COLLEGES OF CHICAGO

LEAVE REQUEST FORM

Employee Status: ☐ Full-Time ☐ Part-Time

Union Status: ☐ NBF ☐ Local 1708 ☐ Local 1600 ☐ Local 3506 ☐ Local 1220 ☐ Local 399 ☐ Local 73 ☐ IEA-NEA

EMPLOYEE INFORMATION:

Name: ______________________	Employee ID ______________________
College/District Office: ______________________	Department: ______________________
Position Title: ______________________	Home Telephone No.: ______________________
Job Family: ______________________	Work Telephone No.: ______________________

LEAVE INFORMATION

Type Of Leave:

	Medical	☐ **Family and Medical Leave (FMLA)**
☐ Illness		
☐ Maternity/Parental (NBF/1600/1708)*	☐ Peace Corp	☐ The birth and or care of a child*
☐ Military Leave	☐ Professional	☐ Placement of a child with the employee for adoption or foster care*
☐ Personal	☐ Special	☐ To care for a spouse, child, or parent with a serious health conditions
☐ Workers' Compensation	☐ Summer	☐ Serious health condition of the employee that makes it impossible for him/her to perform the functions of this job.
☐ Other ______________________		

* Newly eligible child(ren) must be reported to CCC Benefits within 31 days from the date of birth or date of adoption/foster care. Refer to: ccc.edu > Human Resources > Benefits > Coverage, Eligibility & Changes for More information.

Requested Leave: ☐ Paid ☐ Unpaid

Leave Dates: _______/_______/_______ to _______/_______/_______ ☐ Intermittent
(month) (day) (year) (month) (day) (year)

Note: *Short Term Disability or Long Term Disability benefits may be reduced or offset by any salary continuation from CCC or Workers' Compensation as applicable.*

Instructions: Please submit this form to your HR Department or the Benefits Department Leave Management Team. You MUST submit all medical documentation from your health care provider to the Benefits Department Leave Management Team at leavemangagement@ccc.edu within 15 days of submission of this notice request.

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Signature of Employee Date

FOR ADMINISTRATIVE USE ONLY: Approved by District Office of Human Resources ☐ Yes ☐ No

______________________________ ______________________________

Benefits Department Leave Administrator *Date* *College President/Vice Chancellor* *Date*

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Supervisor/Manager *Date*

(Signature of Supervisor/Manager does not constitute final Leave approval)

Approve Leave: ☐ *Paid* ☐ *Unpaid* ☐ *Partially Paid and Partially Unpaid*

Leave Dates: ________/________/________ *to* ________/________/________ ☐ *Intermittent* ______________________
(month) (day) (year) (month) (day) (year) Frequency/Detail