

PENSACOLA STATE COLLEGE

REQUEST FOR LEAVE WITHOUT PAY

(Refer to Procedure 413 for guidelines)

ATTENTION: Director, Human Resources

I, _____ of the _____ Department, hereby
request leave without pay effective from _____ to _____ for the following reason:

- ☐ Educational
- ☐ Personal Emergency
- ☐ Other Medical Condition (non-serious)
- ☐ Insufficient Leave Balance
- ☐ Military Orders

Family and Medical Leave Act (FMLA)

- ☐ Birth/Adoption of a Child
- ☐ Serious Health Condition of Immediate Family Member
- ☐ Serious Health Condition of Employee
- ☐ Military Family Leave

Explanation: _____

I understand I must return to work on the day after this leave expires. If I am unable to work that day, I understand that a new request for leave and associated documents (i.e. physician note) must be submitted before the expiration date specified above. No automatic renewals will be granted; any additional leave will be at the discretion of the President and the Board.

I understand that the college will continue to pay medical and basic life insurance premiums for me for 12 weeks. I will be notified by the Department of Management Services to pay for medical premiums and other benefit deductions to prevent loss of coverage. I understand that any lapse in paid premiums may result in no benefit coverage for me and/or my dependents.

For information and to establish payment for benefit premiums, I understand I must contact People First at (866) 663-4735.

Employee's Signature / Date

Supervisor's Signature / Date

Employee's ID Number

Department Head's Signature/ Date

Employee's Phone Number

*Senior Administrator's Signature / Date

Employee's Mailing Address

* President's Signature/Date