Reset Form

Human Resources
UNIVERSITY OF SOUTH CAROLINA

Employee Request for Leave (P-83)

Instructions
Employees should complete the top portion of this form and submit it to their Department's HR contact. Once the HR contact receives and reviews all necessary supporting documentation, this form, along with the supporting documentation that is provided should be submitted to the Human Resources' Central Benefits Office at HRLeave@mailbox.sc.edu for approval/denial.

To Be Completed by Employee

Name (Last, First, MI):	USCID:		
Department Name:	Campus:		
Address:	City:	State:	Zip Code:
Email Address:	Phone Number:		

Indicate Type of Leave Requested:

- ◯ Authorized Personal Leave Without Pay (Over 10 Days)
- ◯ Military Leave- Short Term (Less than 90 Days) ■
- ◯ Military Leave- Long Term (90 Days or More) ■
- ◯ Adoption Leave ◆
- ◯ Organ Donor Leave∗
- ◯ Administrative Leave∗
- ◯ Sick Leave (Over Three (3) Days) ∗
- ◯ Family Sick Leave (Over Three (3) days)∗
- ◯ FMLA (Birth/Bonding/Adoption)
- ◯ FMLA (To Care for a Family Member)∗
- ◯ FMLA (Self)∗
- ◯ FMLA (Military)∗
- ◯ Annual Leave (Over 30 Days in a Calendar Year)

■ Attach a copy of military orders. ◆ Attach a copy of the adoption papers or letter from attorney/adoption agency.
∗ Attach the appropriate FMLA Medical Certification.

Start Date of Leave:	**End Date** of Leave:

Brief Explanation of Leave Being Requested (*Please do NOT include medical diagnosis information in this explanation.):

Will you be exhausting all your available leave during this absence? ◯ YES ◯ NO

Military Leave Only:

Do you follow a Federal Fiscal Year or a Calendar Year?	◯ Federal Fiscal	◯ Calendar
Will you be using your accrued annual leave?	◯ YES	◯ NO
If yes, how many hours of Annual Leave would you like to use?_____ (hrs.)		
Would you like to continue your insurance benefits while on leave?	◯ YES	◯ NO- Cancel my insurance

Employee Signature (Sign Original in Blue Ink):	Date:

To Be Completed by the Department Head

◯ Approved ◯ Denied

Comments or Reason for Denial:

HR Contact Name:	HR Contact Phone Number:
Department Head Signature (Sign Original in Blue Ink):	Date:

To Be Completed by the Central Benefits Office

◯ Approved ◯ Denied

Comments or Reason for Denial:

Authorized Human Resources Signature (Sign Original in Blue Ink):	Date: