FACULTY ABSENCE FORM

FOR REPORTING **OR** REQUESTING LEAVE

Name:	Department:	
CWU ID #:	Date Beginning:	Date Ending:

Medical	**Non-Medical**
☐ SICK LEAVE (up to 2 weeks) ☐ SHORT TERM DISABILITY (longer than 2 consecutive work weeks) ☐ MATERNITY RELATED DISABILITY LEAVE	☐ CONFERENCE/TRAVEL ☐ BEREAVEMENT ☐ COURT SERVICES ☐ MILITARY ☐ OTHER LEAVE

IF REQUESTING MEDICAL LEAVE

To determine eligibility for Family Medical Leave (FMLA)

Do you anticipate that your leave will be :

	YES	NO
Longer than 2 consecutive workweeks	☐	☐
Cause for intermittent leave	☐	☐

IF REQUESTING NON-MEDICAL LEAVE

COMMENTS / EXPLANATION

The request for leave has been considered and the needs of the department have been met as described below

Classes Affected		Class Meets		Class to be:	If class is Reassigned
Name	Sect #	Days	Time	**C**ancelled **R**eassigned	Name of Instructor

I understand that the chair and the dean must be notified if a leave due to medical reasons is anticipated to last longer than two (2) consecutive workweeks and that medical verification will be required.

Faculty Signature: _____ Date: _____

Chair: _____ Date: _____

☐ **Approved** ☐ **Not approved**

Dean/Director: _____ Date: _____

Original to: Faculty Records Asst., MS 7503
Copies to: HR, MS 7425
Department/dean

Updated 10/31/07