

FACULTY ABSENCE FORM

FOR REPORTING **OR** REQUESTING LEAVE

Name:		Department:												
CWU ID #:		Date Beginning:		Date Ending:										
Medical			Non-Medical											
<input type="checkbox"/> SICK LEAVE (up to 2 weeks) <input type="checkbox"/> SHORT TERM DISABILITY (longer than 2 consecutive work weeks) <input type="checkbox"/> MATERNITY RELATED DISABILITY LEAVE			<input type="checkbox"/> CONFERENCE/TRAVEL <input type="checkbox"/> BEREAVEMENT <input type="checkbox"/> COURT SERVICES <input type="checkbox"/> MILITARY <input type="checkbox"/> OTHER LEAVE											
IF REQUESTING MEDICAL LEAVE			IF REQUESTING NON-MEDICAL LEAVE											
To determine eligibility for Family Medical Leave (FMLA) Do you anticipate that your leave will be : <table style="margin-left: auto; margin-right: auto;"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td>Longer than 2 consecutive workweeks</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Cause for intermittent leave</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>				YES	NO	Longer than 2 consecutive workweeks	<input type="checkbox"/>	<input type="checkbox"/>	Cause for intermittent leave	<input type="checkbox"/>	<input type="checkbox"/>	COMMENTS / EXPLANATION		
	YES	NO												
Longer than 2 consecutive workweeks	<input type="checkbox"/>	<input type="checkbox"/>												
Cause for intermittent leave	<input type="checkbox"/>	<input type="checkbox"/>												
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	<u>C</u> ancelled <u>R</u> 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: _____										
<input type="checkbox"/> Approved <input type="checkbox"/> Not approved														
Dean/Director: _____				Date: _____										