



FACULTY APPLICATION FOR LEAVE ALLOWANCE

(Employee completes this form if the no. of continuous days of absence exceeds the no. of days/week of assignment [Reference: CBA Article 17.C.6.1])

1. Employee: Submit to Department Chair & Dean for approval
2. If 17.B Unpaid Leave or 17.N Partial Load Reduction, submit to Department Chair, Dean & AVC for approval.
3. Submit to Human Resources with supporting documentation (Ocean Campus, **Bungalow 702** -- 415/452-7660 – fax: 415/452-7786)

ID#	Name			<input type="checkbox"/> PT <input type="checkbox"/> FT
Home Address:		Mailbox	Work Phone	Home Phone
Department				

ELIGIBILITY REQUIREMENTS

Leave Type: Time period on any one application cannot extend beyond the academic year. Contact Human Resources for Pregnancy Disability Leave, FMLA/CFRA or CalSTRS Pre-Retirement Reduced Workload leave requests.

Short-Term (20 Days or Less), Request shall be filed no later than 5 working days prior to the requested beginning day of leave.

Long-Term (More than 20 Days), Request shall be filed within 10 days following the beginning of the current semester for the following semester (January 30 for Fall Semester and August 30 for Spring Semester). **Employees on unpaid leave are required to pay both employee's and employer's medical premiums.**

1. I AM REQUESTING A LEAVE (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Sick Leave (17.C) A signed certification from a Health Care Provider is required. | <input type="checkbox"/> Unpaid Short-Term Leave < 20 days (17.B) |
| <input type="checkbox"/> Partially Paid Sick Leave ("A" days) (17.D) FT Faculty may request if they have exhausted their sick leave benefits. A signed certification from a Health Care Provider is required. | <input type="checkbox"/> Unpaid Long-Term Leave > 20 days (17.B) |
| <input type="checkbox"/> Pregnancy Disability Leave PDL (17.G) A signed certification from a Health Care Provider is required. | <input type="checkbox"/> Partial Load Reduction (17.N): FT Tenure Track only; FT Categorical/Grant Funded are not eligible. |
| <input type="checkbox"/> Family Medical Leave under the FMLA(17.H) (FT Faculty only) | (If the request for Partial Load Reduction is due to medical reasons, select Sick Leave 17.C not 17N. If you wish to use your sick leave supporting medical certification from a Health Care Provider is required.) |
| <input type="checkbox"/> California Family Rights Act (CFRA) (FT Faculty only). | <input type="checkbox"/> Military Leave (17.P) (Attach orders) |
| <input type="checkbox"/> If this absence is due to an Industrial Injury (Workers' Compensation) (17.I), employees are required to complete the Workers' Compensation Forms – available at www.ccsf.edu/workcomp | <input type="checkbox"/> Professional Growth (17.M)
Attach description of activity & supporting documents. |

2. DURATION & PERCENT OF LEAVE

Please indicate the period and percent of leave or dates of leave you are requesting, using the appropriate box below.

- ☐ Academic Year: 100% leave (20_____/20_____) ☐ Semester: Fall (year): _____ at _____% of leave AND / OR Spring (year): _____ at _____% of leave.
- ☐ Dates: _____ to _____ at _____% ☐ I was previously awarded: ☐ Long-Term Leave (semester/year) _____ and/or ☐ Sabbatical Leave (semester(s)) _____

3. REASON FOR LEAVE and/or REASON FOR LATE REQUEST

Please be specific and attach supporting documents

*Only personal business of a compelling nature, religious holidays, and appearances in court as a litigant require prior management approval. Employees may submit this form directly to the appropriate administrator in a sealed envelope in order to assure confidentiality.

WARNING: Time spent on leave may affect your retirement eligibility/benefits. Check with your retirement system.

CERTIFICATION: I certify that this leave of absence is for the purpose indicated above and I acknowledge that certain deadlines may apply. I further certify that I understand that where no leave extension has been received and granted, and no emergency exists to prevent return on the specified date, failure to return shall result in the following: District shall begin immediate processing for the securing of a written resignation and/or begin immediate processing for my discharge.

Signature

Date

Department Chair:	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved (Signature) _____	(date) _____
Dean:	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved (Signature) _____	(date) _____
AVC / VC:	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved (Signature) _____	(date) _____
HR Officer/Designee:	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved (Signature) _____	(date) _____