Reset Form

UNIVERSITY OF SOUTH CAROLINA

# Request for Leave Without Pay / Return from Leave Without Pay

| To Be Completed by the Department | | | |
|---|---|---|---|
| Name: (Last, First, Middle) | | | |
| USC ID: | Class/Slot: | Title: | |
| Pos. No.: | Dept. Name: | | Dept. No.: |

| Going on Leave Without Pay | | | |
|---|---|---|---|
| LWOP for over 10 working days must be applied for in advance of the leave being taken. Approval by the Division of HR is required. | | | |
| Select One: Authorized ◯ | Unauthorized ◯ | Suspension ◯ | |
| Select One: Personal (If selected, must attach letter of explanation) ◯ | | Illness or Disability ◯ | |
| Expected Dates of LWOP: | through: | | |
| For FMLA qualified illnesses (3 days or more in length), has the Employee Medical Certification form (P-75) – or in the event of a family member's illness, the Family FMLA Certification form – been completed and sent by the physician to the Benefits Office? (See Sick Leave Policy.) | | Yes ◯ | No ◯ |
| Reason for LWOP: | | Job Related: Yes ◯ | No ◯ |
| Is the employee a foreign national? Yes ◯ | No ◯ | If yes, contact ISFS at ISFS@sc.edu. | |

| Signatures | Dates |
|---|---|
| **I understand that I am responsible for notifying the Benefits Office (as applicable) within 2 business days of signing this form to discuss options for my insurance coverage during the leave period. I further understand that I am also required to notify the Benefits Office (as applicable) within two days of returning to work date following the leave without pay period to be advised regarding insurance coverage. I understand that if I am a Faculty member, there are certain procedures that may be required by the Provost's Office. I will follow up accordingly to ensure those procedures are followed.** | |
| **Employee:** | |
| **If the employee does not sign this form, I will contact the Benefits Office (if applicable) within 2 business day of signing this form to notify of this action and initiate communication to the employee in relation to insurance coverage.** | |
| **Supervisor:** | |
| Approved Disapproved | Human Resources: |

| Return from Leave Without Pay (Over 10 days duration) | |
|---|---|
| Date of Return: | Date LWOP Began: |

**Accounting (Attach additional sheets if more space is needed)**

| Department | Fund | Obj. Class | Analytical | FV | FSO | C | Percent | Amount |
|---|---|---|---|---|---|---|---|---|
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| To Be Completed by Division of Human Resources/Payroll | | | |
|---|---|---|---|
| Base Salary: | Supplement: | Total Salary: | |
| Semi-Amt: | OR: ( + / - ) | PB: | Hrs/Week: |
| SSD: | LBD: | | |

| Signatures | | | |
|---|---|---|---|
| Salary Administration: | Date: | Payroll: | Date: |

- For Faculty LWOP, if foreign national is indicated, please forward a copy to International Support for Faculty and Staff.