LEAVE REQUEST AUTHORIZATION

American Samoa Community College
Human Resources Department

Name of Employee	Date	☐ Faculty ☐ Staff ☐ Contract Specialist
Department/Division	Work Phone: Home Phone:	Employee ID#

I understand that leave must be requested and approved in advance (3 days) before commencement of leave. I understand that I must provide sufficient information so the proper type of leave can be determine. I understand that I am responsible for keeping my supervisor informed of any change in this request. I understand that verification by HR will determine hours leave and approval by appropriate authority.

I request __ hrs/ _ day (s) as listed below. Is the absence due to a work-related illness or injury? ☐ Yes ☐ No

Record dates, times, and number of hours in the blanks before each applicable reason. Actual Dates & Times

From		**To**		**# Hours**	**Reason**
Date	Time	Date	Time		
					Annual –
					Sick –
					Other – (check the box for type of leave)

OTHER LEAVE: ☐ Administrative ☐ Bereavement ☐ *Family Medical Leave ☐ Military ☐ Unpaid
☐ Comp/Flex time ☐ Maternity ☐ Release time (faculty only) ☐ Jury ☐ *Prof Development

*****_Request for Part II, if applying for Family Medical Leave Act of this form from Human Resources._
*_Request for Part III, if applying for Professional Development Leave of this form from Human Resources_**.**

Employee Signature: Date: ☐ Amended Request

TO BE COMPLETED BY Human Resources Department
Eligible for "Other type of Leave": ☐ Yes ☐ No

Accrued Annual Leave as of:	# of hours:	Date:	**Verified:**
Accrued Sick Leave as of:	# of hours:		
Accrued comp time as of:	# of hours		

Note: HR will complete the verification of "leave accounts" and will route the request to appropriate approval levels.
Copy of approved leave will be provided to the employee and the Division Supervisor. Any changes to leave requests shall be forwarded to Human Resources to correct original copy before processing payroll.

HR Department Remarks:

APPROVAL(s):

/
Immediate Supervisor - (pre-approval and recommend for approval (if applicable) **Date:**

/
Dean/Director or Designee Signature - (approval up to 24 hours/ 3 working days) **Date**

/
Vice President or Designee Signature - (approval of 25 hours 160 hours/ 4-20 working days) **Date**

/
President's /BHE Chairperson Signature - (approval of more than 160hrs/or 21+ working days) **Date**

Comments:

HRO Posted to Payroll by: / Date

FMLA LEAVE OF ABSENCE – PART II

Name:	Work Phone: Home Phone:	Leave Control #

COMPLETE PART II (FMLA) LEAVE REQUEST

A medical certification ☐ is required ☐ is not required. (Required for more than 3 full consecutive working days.)

A medical certification ☐ is required ☐ is not required. (Required for absences of more than 30 days.)

For purpose of family/medical leave designation. It has been determined per the following: (Mandatory)

☐ The employee is not eligible for FMLA until _____ (date)
☐ The employee is eligible but has used the hours allowed this pay year.
☐ The event does not qualify for FMLA.
☐ Continuation of a previously designated event (continuing treatment or recovery).

Employee who have worked for at least 1,250 hours during the 12-month period immediately prior to their request for leave are eligible for FMLA leave of absence.

TYPE OF LEAVE REQUESTED:
☐ Employee Medical Leave of Absence
☐ Family Medical Leave of Absence
☐ To care for newborn, adopted child, child placed for foster care

The leave requested will begin on _____ (day/mo/year) and end on _____ (day/mo/year)

REASON FOR LEAVE:
☐ My personal serious health condition
☐ Birth of my child
☐ Adoption of a child
☐ Place of child with me for foster care
☐ Serious health condition of my child
☐ Serious health condition of my parent
☐ Serious health condition of my spouse

PROFESSIONAL DEVELOPMENT LEAVE
PART III

ACADEMIC YEAR _____
COLLEGE _____
DIVISION/DEPT _____

DURATION **One Semester:** _____ Fall Semester ____ Spring Semester
PDL COMMITTEE
RECOMMENDATION:_____
_____
_____
_____
_____

PROPOSED ACTIVITIES:
(Add additional sheets, if needed.)

LEAVE OF ABSENCE WITHOUT PAY NOTIFICATION
American Samoa Community College
Human Resource Department

Employee: _____ Department/Position: _____

Employees may be granted a leave of absence without pay for the reasons outlined in the ASCC Policy & Procedural Manual, Policy #4500, and Leave of Absence. This type of leave may be granted at the discretions of Director/Dean of the Department. The information provides below is necessary for a better understanding of your leave dates and your responsibilities before and during leave.

You are authorized ____days as leave of absence without pay beginning _____ and ending _____.
This leave of absence is granted for the following purpose (check one).
☐ Sick ☐ Education ☐ Military ☐ Personal

If continued coverage of medical benefits and creditable services, you must arrange, in advance, with the Human Resources Office.

You will be expected to return to work (at your prior work commitment) not later than the date specified above.

You may return from your leave of absence prior to the above date; however, a minimum of two weeks notice is required because a temporary replacement may be hired. If you do not expect to return to work until the above date, you must notify your supervisor or department head at least one week prior to return for verification.

Supervisor's Signature: _____ Date: _____

Dean/Director's Signature: _____ Date: _____

I understand the above and have received a copy of this notification.
Employee's Signature: _____ Date: _____

Distribution: Original – Human Resources, Copy – Employee and Supervisor/Dean/Director

ASCC HR 4500.15

American Samoa Community College

LEAVE SHARING APPLICATION

This form is to be completed by the employee and submitted to the Supervisor/Department Head for approval. Application is forwarded to Human Resources. The employee will receive a copy of the approved application.

To:

From:

Subject: Application for Shared Leave

Date:

I am requesting Shared Leave due to:

☐ My own serious health condition
☐ Parent
☐ Child
☐ Spouse
☐ Military Caregiver Leave

Leave will begin on: _____and expected leave to continue until on or about: _____
(mo/day/yr) (mo/day/yr)

REQUIRED DOCUMENTS

1) CERTIFICATION OF PHYSICIAN form on file in Human Resources. ☐ Yes ☐ No
2) Documented Proof of Relationship on file with Human Resources. ☐ Yes ☐ No ☐ NA
3) Copy of Approved ASCC Leave Request with Human Resources. ☐ Yes ☐ No

_____ _____
Employee's Signature Date

VERIFICATION BY HR: Meets all requirements for Leaver Sharing per ASCC Policy 4500.18

_____ _____
HR Officer ☐ YES ☐ NO Date
Reason for ineligibility: _____
_____

APPROVAL:

_____ _____
Signature Date

President – up to 30 days/240 hours
Vice President – up to 20 days/160 hours
Dean/Directors – up to 10 days/80 hour

Copy to: Applicant (Employee) _____ Date
HR File _____ Initials

American Samoa Community College

Leave Sharing Pledge/Nomination

Instruction: Please complete Section I to pledge to the program, and complete Section II if you have a nomination for a recipient. For further assistance contact HR Office: 699-9155 ext. 436 or 335.

SECTION I - Donor's Pledge:

Name of Employee	Division/Department	Position

I would like to donate leave:

☐ Annual: _____ Hours - to date: _____ (mo/day/year)

☐ Sick: _____ Hours - to date: _____ (mo/day/year)

Signature of Donor: _____ Date: _____

SECTION II – NOMINATION

I nominate this employee as the Recipient: _____

_____

Name

Division

** Please return form to the Human Resources Division*

SECTION III – LEAVE ACCOUNT STATEMENT (HR use only)

Annual Leave _____ to date: _____ (mo/day/year)

Sick Leave _____ to date: _____ (mo/day/year)

Amount of leave used for Nominated Recipient: _____

Amount of leave left in Leave Sharing Pool: _____

Signature of HR Representative: _____ Date: _____

Copy to: Donor
File

ASCC HR 4500.18A