Charles R. Drew University of Medicine and Science
A Private University with a Public Mission

Request to Utilize Donated Leave

NAME:	EMPLOYEE ID:	
JOB TITLE:	DEPT:	
SUPERVISOR NAME:	SUPERVISOR PHONE NO.:	
NUMBER OF HOURS REQUESTED:	BEGIN DATE:	END DATE:

Note: *Leave hours requested should not exceed six work weeks or 240 hours for full-time employees (part-time requests will be pro-rated based on the employee's regularly scheduled hours). Leave benefits will be integrated with disability benefits (State Disability Insurance and Short and/or Long-term disability).*

This request must be supported by a Certification of Health Care Provider.

Employee Signature:_ _____ Date: _____

HR Business Partner Name: _____

HR Business Partner Signature: _____ Date: _____

Please email your request to hrdept@cdrewu.edu