



**UNPAID LEAVE OF ABSENCE  
COMPASSIONATE CARE LEAVE**

**TO BE COMPLETED BY THE EMPLOYEE:**

Name: \_\_\_\_\_ Employee #: \_\_\_\_\_  
 Address: \_\_\_\_\_ School/Site: \_\_\_\_\_  
 \_\_\_\_\_ Assignment/Position: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_

Dates of Leave (inclusive): \_\_\_\_\_

Explanation of Circumstances for the Request: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Employee Signature Date Submitted

**TO BE COMPLETED BY SUPERVISOR:**

RECEIVED

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Supervisor Signature Date

DOCUMENTATION COMPLETED:

\_\_\_\_\_  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_