MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

NOTICE of LEAVE of ABSENCE

SECTION I: Employee and Department Information

Employee Name: _____
Employee ID: _____
Position Title: _____
State Position #: _____

Completed by: _____
Department Unit #: _____
Department Name: _____

Last Day Worked (1): _____
Last Day Paid (2): _____
Expected Return Date (3): _____

Is this in conjunction with FMLA?
- ◯ Yes
- ◯ No

(1) **Last Day Worked**: Last day the employee is at work providing service for MUSC.
(2) **Last Day Paid**: Last day the employee received compensation at work or in an approved paid leave status.
(3) **Expected Return Date**: Date when the employee is expected to return to work.

SECTION II: Reason for Leave of Absence

Select one:

1 ◯ Maternity/Adoption/Foster Child
2 ◯ Military
3 ◯ Education
4 ◯ Workers' Compensation
5 ◯ Family Medical Emergency
6 ◯ Personal Illness
7 ◯ Sabbatical
10 ◯ Intermittent Activity

SECTION III: FMLA Eligibility Verification

Verify FMLA Eligibility:

- ◯ Employee does not qualify – Go to Signature
- ◯ Employee has already exhausted FMLA time – Go to Signature
- ◯ Employee is eligible – Indicate completion of steps below
  - ☐ Verbal notification given
  - ☐ Written notification given
  - ☐ Completion of Physician or Practitioner Certification or Childbirth/Adoption/Foster Care Form

    Start Date of FMLA coverage: _____
    End Date of FMLA coverage: _____ (Expected End Date)

SIGNATURE

_____ _____ _____
Departmental Representative Signature *Date* *Phone*

Send form to Department of Human Resources Management, HOT Suite 102, P.O. Box 250800

For assistance or clarification, contact the HRM department at 792-5075.