

WASHINGTON STATE UNIVERSITY

**MILITARY FAMILY LEAVE
EMPLOYEE REQUEST FORM
COVERED SERVICEMEMBER**

Please return form to: WSU Human Resource Services (HRS)
 Office Location: 139 French Administration Building
 OR Mailing Address: PO Box 641014
 Pullman, WA 99163-1014
 OR Fax: 509-335-1259
 Questions? Call HRS at: 509-335-4521

A EMPLOYEE INFORMATION (please print)								
Name (Last, First, MI)				Personal Email			WSU ID #	
Home Mailing Address (Street/PO Box, City, State, Zip Code)							Personal Phone	
B CURRENT SERVICEMEMBER INFORMATION								
Must be a current member of the Regular Armed Forces, the National Guard, or the Reserves.								
Name (Last, First, MI)								
Relationship of veteran to employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Next of kin (describe):								
Please provide the servicemember's current military branch, rank and unit.								
Military Branch			Rank			Unit		
Is the servicemember receiving medical treatment, recuperation, or therapy for an injury or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Describe care to be provided by the employee to the servicemember								
C LEAVE REQUEST TIME PERIOD								
<input type="checkbox"/> I am requesting full-time leave from ____/____/____ through ____/____/____ <input type="checkbox"/> I am requesting to reduce my work schedule from # ____ hours to # ____ hours per day/week beginning ____/____/____ through ____/____/____ <input type="checkbox"/> I am requesting an intermittent work schedule from ____/____/____ through ____/____/____ or other schedule as described below (describe):								
D LEAVE BALANCES REPORTED ON LAST TIME/LEAVE REPORT								
Time/Leave Report Month (MM/YYYY)			Annual Leave Balance			Sick Leave Balance		
I wish to use leave as estimated below:								
Leave Without Pay			Annual Leave			Sick Leave		
From Date	Through Date	Hours	From Date	Through Date	Hours	From Date	Through Date	Hours
Total Annual Leave Hours			Total Sick Leave Hours			Total LWOP Hours		
I wish to use my Personal Holiday on: (date) ____/____/____								
E EMPLOYEE SIGNATURE								
In requesting leave, I understand that if my request for leave information is incomplete or insufficient, WSU may not approve the leave. I also understand and release appropriate HRS professionals (e.g. official HRS personnel only-not my supervisor or department management) to contact my Health Care Provider to authenticate (confirm signature) or clarify information provided (understand handwriting or meaning of response). If I refuse to provide this release, I understand that WSU can deny my request for leave.								
Employee Signature							Date	