

# WASHINGTON STATE UNIVERSITY

## MILITARY FAMILY LEAVE EMPLOYEE REQUEST FORM COVERED VETERAN

**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 | COVERED VETERAN INFORMATION

Must be a veteran who has been discharged within the last five years under conditions other than dishonorable.

Name (Last, First, MI)	Date of veteran's discharge
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Relationship of veteran to employee:  
 Spouse  Parent  Son  Daughter  Next of kin (please describe):

Please provide the veteran's military branch, rank and unit at the time of discharge

Military Branch	Rank	Unit
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Was the veteran **dishonorably** discharged or released from the Armed Forces (including the National Guard or Reserves)?  
 Yes  No

Is the veteran receiving medical treatment, recuperation, or therapy for an injury or illness?  Yes  No

**Describe care to be provided by the employee to the veteran**

### C | LEAVE REQUEST TIME PERIOD

I am requesting full-time leave from \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_

I am requesting to reduce my work schedule from # \_\_\_\_ hours to # \_\_\_\_ hours per day/week beginning \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_

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
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I wish to use leave as estimated below:

Leave Without Pay (LWOP)			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
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