



## CRISIS LEAVE REQUEST FORM

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Name: \_\_\_\_\_ LSU ID Number: \_\_\_\_\_

Campus Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

I (or family member/relation) have a crisis situation that may qualify for crisis leave as confirmed by the attached Family Medical Leave Act (FMLA) form, which includes: physician's certificate, which provides information about the patient's condition, nature of illness/ injury, any relevant medical history, type of treatment prescribed, prognosis and the ability to return to work.

I am requesting crisis leave for the following dates: \_\_\_\_\_ (start date) to \_\_\_\_\_ (end date).

I understand that the value of annual leave granted as crisis leave cannot exceed 75% of my pay in a regular work week, and that crisis leave is limited to 240 hours per calendar year. Further, I understand that I will not accrue leave while using crisis leave.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Approval by Leave Pool Manager: \_\_\_\_\_

Disapproval by Leave Pool Manager: \_\_\_\_\_ Date: \_\_\_\_\_

Requests should be made at least 10 days before the crisis leave is needed. Employee will be contacted by HRM within five work days regarding the status of the request.

Please submit to Office of Human Resource Management, 110 Thomas Boyd Hall.

*\*The request must be accompanied by the FMLA form.*