

UNIVERSITY OF SOUTHERN CALIFORNIA
FACULTY FAMILY LEAVE REQUEST
 (Full Time Faculty Only)

NAME: _____

DATE: _____

EMPLOYEE # _____

SOCIAL SECURITY # _____

TITLE: _____

DATE OF HIRE: _____

DEPARTMENT: _____

WORK PHONE: _____

PURPOSE OF LEAVE

TYPE OF LEAVE

- _____ Fathered a child*
- _____ Gave birth to a child*
- _____ Care for adopted child under the age of six*
 (Document verifying placement is required)

_____ Full-Time: Start Date _____ End Date _____

_____ Part-Time: Start Date _____ End Date _____

SIGNATURES:

Faculty Member: _____

Date: _____

Chairperson: _____

Date: _____

Dean/Director: _____

Date: _____

Provost: _____

Date: _____

* Should be taken within six months of the birth/placement.

**SUBMIT TO DISABILITY OFFICE
 FOR REIMBURSEMENT PURPOSES**

(CREDIT)

Pay Cycles: _____

Compensation	Account Number	Object Code	Amount
Salary (monthly)		05000	
Fringe/Rate		05000	

 Home Department Signature

 Date

(To be completed by Disability Department, Ext. 05875)

(DEBIT)

Pay Cycles: _____

Compensation	Account Number	Object Code	Amount
Salary		24100	
Fringes	11 0464 0004	24100	
Disability /PFL Applied <input type="checkbox"/> E/T	29-9010-2000		