Central Community School System
Leave Without Pay

Employee Name: _____ Employee ID: _____

School/Department: _____ Job Title: _____

Home Address: _____

Home Number: _____ Cell Phone Number: _____

Requested Beginning Date: _____ Requested Ending Date: _____

_____ I wish to request approval of Leave Without Pay. I understand that I will receive no salary when Leave Without Pay begins. I understand that I am responsible for payment of any benefits I may have through the Central Community School System while on a Leave Without Pay.

Reason for Leave Without Pay request: _____

_____

_____

_____

Do you plan to return to the Central Community School System when this Leave Without Pay is completed?

_____ Yes _____ No

Employee Signature: _____ Date: _____

_____Approve _____Disapprove

Principal or Supervisor Signature: _____ Date: _____

_____Approve _____Disapprove

Director of Human Resources: _____ Date: _____

PLEASE RETURN COMPLETED FORMS TO:
CENTRAL COMMUNITY SCHOOL SYSTEM
POST OFFICE BOX 78094
CENTRAL, LA 70837