# Compassionate Leave Request Form

Employee: Complete and submit this form to your Department Director and then return signed form to Human Resources Department

**Fax:** 904.209.2414 **Email:** bccbenefits@sjcfl.us

I, _____, have read and understand the St. Johns County
*(Print Name)*
Compassionate Leave policy (Administrative Code Section 408), and hereby request Compassionate Leave hours (not Family Medical Leave under the provisions of the Act). My request is supported by my previously approved FMLA or the attached document(s) and is for the following time period:

Beginning on _____ Ending on _____
*(Date)* *(Date)*

I understand that while I am using Compassionate Leave, I may not be entitled to accrue sick or vacation leave, nor merit or any other type of pay increases. I am willing to accept donated vacation hours from St. Johns County Board of County Commissioners' employees and understand that hours donated to me will be used on an as needed basis subject to eligibility and availability. I confirm that I have not directly or indirectly solicited or coerced employees to donate leave time to me. I acknowledge my responsibility to periodically report on my status and intent to return to work as directed by Human Resources and that failing to return to work by the expiration date of approved leave may result in my separation from County employment.

_____ _____
Employee Signature Date Signed

_____ _____
Department Name Employee #

**For Use by Department Director Only**

☐ Recommended ☐ Not Recommended _____ _____
Department Director Signature Date

**For Use by Human Resources Department / County Administration Only**

Additional Notes:

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|---|
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☐ Approved ☐ Not Approved _____ _____
County Administrator Date

cc: HR Department Files