Compassionate Leave Request Application

Compassionate Leave is a fund that MCCCD employees voluntarily donate vacation and sick leave hours so that eligible employees may receive a portion of paid leave hours up to the first 90 days of a qualifying non-work related disability.

Compassionate Leave:

- paid on MCCCD's regular payroll cycle
- concludes when an employee returns to work or has surpassed the first 90 days, whichever is first
- pays $33\frac{1}{3}$ % of an employee's bi-weekly salary
- is separate from Short-Term disability
- paid out may be less than the amount approved if money is owed to MCCCD

An employee requesting Compassionate Leave must:

- be a full-time/benefitted classified or non-classified employees
- be on an MCCCD approved FMLA/Medical leave
- have a non-work related serious illness or injury, as verified in writing by a health care provider, which meets the definition of a serious health condition under FMLA; **or** have a ***family member with a serious illness or injury, as verified in writing by a health care provides, which meets the definition of a serious health condition under FMLA
- be prevented from returning to work for a minimum of 30 consecutive work days
- have exhausted all accrued leave (sick, vacation and banked vacation)

***Family - Family members are defined as spouse or dependents of an employee who reside in the same household.**

Submit completed form to: **Leaves Administration Department, District Office**
Attn: Compassionate Leave Committee, Confidential

Employee Section

Employee's Name: _____ Employee ID: _____

Employee Mailing Address: _____

If request is based on family member's condition

Family Member's Name: _____Relationship to Employee: _____

Does family member reside with the employee? ☐Yes ☐ No

Are you currently on any type of leave (FMLA, Health or ADA)? ☐ Yes ☐ No

Dates of approved leave: _____to _____

Requested Start Date of Compassionate Leave: _____Ending Date: _____

I certify that all of the above information is correct to the best of my knowledge. I give permission to the Compassionate Leave Committee to review any information submitted with this application. I understand that I will be notified as to the status of my request by the Compassionate Leave Committee within ten business days of my request.

Employee signature: _____ Date: _____

LEAVES ADMIN USE ONLY						
Date Received:				Date Processed:		
Verified by:		Approved	Denied	Unpaid Date:		
Med Doc	Abs Wksht	Par		Comp Sheet	Notification	Spreadsheet