SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
LEAVE POOL REQUEST FORM

Employee Section:

Name:_____

Personnel Number:_____

Division/Regional Center/Central Office:_____

Home Address *(include zip code)*:_____

Work Phone:_____ Cell Phone:_____

Email Address:_____

I am scheduled to work: _____hours a day _____days a week

I request: _____Sick Leave Hours or _____Annual Leave Hours

Reason for Request: (Reason/details, illness, injury or personal)

_____

_____

_____

_____

Leave history: *(Please explain why you do not have sufficient leave to cover this request)*:

_____

_____

_____

_____

I have read the DDSN Leave Transfer Pool Directive (413-07-DD), and I understand that if my request for leave is approved, I am subject to the terms of the DDSN Leave Transfer Program guidelines and any unused leave will be returned to the Leave Pool Program. I understand that I must also comply with all other DDSN Policies and Procedures regarding leave with or without pay.

Employee Signature:_____ Date:_____

Human Resources Section:

Class/Position:_____

Salary Rate:_____ Hourly Rate:_____

Director of Human Resources Signature:_____