



**Compassionate Care and Emergency Leave (CCEL)  
Staff Member Leave Benefit  
Application Form**

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Staff Member Name: \_\_\_\_\_

ID Number: \_\_\_\_\_

Department: \_\_\_\_\_

Date: \_\_\_\_\_

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Dates of the Requested Leave: \_\_\_\_\_

Have you already spoken to someone in your department about the leave? Yes      No

If yes, who:

Reason for the Leave:

Is Supporting Medical Documentation Attached? Yes

No

n/a

Contact information to obtain documentation if not attached:

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If you will be away from your primary residence during your leave, please provide contact information in the event we need to reach you to discuss your leave application

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Signature: \_\_\_\_\_

**Return to:** Health Promotion and WorkLife Services, Human Resource Services, 2-60 University Terrace, 8303 112 St NW, Edmonton, Alberta, Canada T6G 2T4 or fax to: 780.492.0798