



Leave of Absence Request Form

SECTION A - TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT OR TYPE)
Date of Request
Name (first, middle initial, last)
Address (include city, state and zip code)
Home Phone # () Department & Extension Classification Work Schedule
Date leave to begin: Last day worked:
Date leave to end: Return to work date:
Reason for Leave Request (* indicates Family Medical Leave of Absence)
[] Serious Medical Condition of Employee* [] Placement of Foster Child with Employee*
[] Serious Medical Condition of Family Member* (specify relationship) [] Military Leave
[] Employee's Pregnancy* [] Education Leave
[] Birth of Employee's Child* [] Personal Leave (Please explain):
[] Adoption of Employee's Child
** Medical certification/supporting documentation must be submitted directly to HRM
Circle yes or no for each insurance plan you wish to continue during your leave. (See benefits section on the back of this form before completing).
Medical (Yes / No) Dental (Yes / No) Vision (Yes / No)
Circle yes or no for Non-Industrial Disability (See NDI section on back of this form) (Yes / No)
I certify that all the facts are true and correct to the best of my knowledge. If my request for a Leave of Absence is approved, I understand that I must abide by all of the terms and conditions of my leave of absence. If I am unable to return to work on the specified date, I am to notify HRM of the change. Failure to notify HRM may result in my being absent without authorization.
Employee Signature Date:
SECTION B - TO BE COMPLETED BY SUPERVISOR
Department Head Date Approved [] Yes [] No
Fiscal Administrator Date Approved [] Yes [] No
Dean/Vice President Date Approved [] Yes [] No
Reason of Denial Recommendation:
SECTION TO BE COMPLETED BY HUMAN RESOURCES MANAGEMENT (HRM)
Associate Vice President, HRM Date Approved [] Yes [] No