

# PERSONNEL LEAVE OF ABSENCE FORM

(to be completed by Employee)

Note: Please refer to contract provisions regarding leave of absence. ~~Initial~~ approval may be given verbally, but will be confirmed in writing.

Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
School/Department: \_\_\_\_\_ Position: \_\_\_\_\_  
Type of Leave Requested: ' FAMILY ' OTHER ' BOTH

## FAMILY LEAVE INFORMATION

All employees are entitled to 12 weeks of unpaid leave in a 12-month period. Employee health benefits will be maintained during this unpaid leave. Employee is responsible for paying the Chapter 78 portion of benefits premium while out on leave for benefits.

Reason for Leave: ' Birth/Adoption/Foster Care of Child  
' Family Member Health Condition\*  
' Employee Health Condition\*

Leave to start: \_\_\_\_\_ Leave to end: \_\_\_\_\_  
Remarks: Personal (no pay, no benefits unless employee pays premiums)

Leave to start: \_\_\_\_\_ Leave to end: \_\_\_\_\_

Are you requesting an extension of an existing leave? \*\*Yes ' No  
If Yes, indicate type of prior leave: \_\_\_\_\_  
Reason for leave/Remarks: \_\_\_\_\_

\* Attach appropriate documentation from physician

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## SICK DAYS/VACATION DAYS/PERSONAL DAYS

If you intend on using Sick Days, Vacation Days (12 month employees only) and/or Personal Days prior to the requested leave, please indicate the dates below:

\_\_\_\_\_ Sick Days Dates: \_\_\_\_\_  
\_\_\_\_\_ Personal Days Dates: \_\_\_\_\_  
\_\_\_\_\_ Vacation Days Dates: \_\_\_\_\_

( P S O R \ H H ¶ V 6 L J Q D W X U H B B B B Date: \_\_\_\_\_

TO BE COMPLETED BY CENTRAL OFFICE ADMINISTRATION