LEAVE OF ABSENCE REQUEST

FOR DEPARTMENT USE ONLY: Personnel Program or Collective Bargaining Agreement:

SECTION I – TO BE COMPLETED BY THE EMPLOYEE

EMPLOYEE'S NAME	TELEPHONE	CAMPUS
DEPARTMENT	TITLE	EMPLOYEE ID

☐ Initial Application

☐ Amendment to LOA that began on

____

Reason for Leave of Absence:

☐ Own Injury/Illness (not work-related)
☐ Care for Injured/Ill Family Member
☐ Pregnancy/Disability
☐ Care for Newborn/Placed Child
Date of Birth/Placement _______________
☐ Union Business
☐ Work-Incurred Injury/Illness
☐ Professional Development
☐ Military Caregiver Leave
☐ Qualifying Exigency Leave
☐ Administrative
☐ Military
☐ Other (specify):

Requested start date

____

Anticipated return date:

____

Requested intermittent or reduced work schedules

Do you have UC medical insurance?	Do you have UC dental insurance?	Do you have UC optical insurance?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Have you or will you be filing a University Disability Insurance claim? ☐ Yes ☐ No

A leave of absence is normally leave without pay. Paid leave (accrued sick leave or vacation) may be substituted for all or a portion of the unpaid leave in accordance with appropriate policies/contracts.

☐ I wish to use paid leave as indicated below: (attach additional sheets if necessary)

	(MM/DD/YYYY)	(MM/DD/YYYY)
_______ Hours of accrued sick	Begins on _______________	and ends on _______________
_______ Hours of accrued vacation	Begins on _______________	and ends on _______________

EMPLOYEE'S SIGNATURE:	DATE:	TELEPHONE:

SECTION II – TO BE COMPLETED BY THE UNIVERSITY

APPROVAL/DENIAL OF LEAVE REQUEST

	(MM/DD/YYYY)	(MM/DD/YYYY)
☐ Your request for leave is approved and	Begins on _______________	and ends on _______________
____ weeks ____ days ____ hours qualify as FM leave under FMLA	Begins on _______________	and ends on _______________
____ weeks ____ days ____ hours qualify as FML leave under CFRA	Begins on _______________	and ends on _______________
____ weeks ____ days ____ hours qualify as PDL leave under PDLL	Begins on _______________	and ends on _______________
____ weeks ____ days ____ hours qualify as (Specify)____________________	Begins on _______________	and ends on _______________

Family and Medical Leave

☐ Your request for FML is not approved for the reasons set forth on the Designation Notice.

Other Leaves

☐ Your requested leave is not approved for the following reason(s):

____

PAY STATUS DURING LEAVE

		(MM/DD/YYYY)	(MM/DD/YYYY)
Sick Leave	_______ hours to be applied	Begins on _______________	and ends on _______________
Extended Sick Leave	_______ hours to be applied	Begins on _______________	and ends on _______________
Vacation	_______ hours to be applied	Begins on _______________	and ends on _______________
Leave without pay	_______ hours to be applied	Begins on _______________	and ends on _______________

(Attach additional sheets if necessary)

DEPARTMENT SIGNATURE

NAME (PRINT)

SIGNATURE	DATE