

LEAVE OF ABSENCE REQUEST

SECTION I – TO BE COMPLETED BY THE EMPLOYEE

EMPLOYEE'S NAME	TELEPHONE ()	CAMPUS
DEPARTMENT	TITLE	EMPLOYEE ID

<input type="checkbox"/> Initial Application <input type="checkbox"/> Amendment to LOA that began on _____	Reason for Leave of Absence:		
<input type="checkbox"/> Own Injury/Illness (not work-related) <input type="checkbox"/> Care for Injured/III Family Member <input type="checkbox"/> Pregnancy/Disability <input type="checkbox"/> Care for Newborn/Placed Child Date of Birth/Placement _____	<input type="checkbox"/> Union Business <input type="checkbox"/> Work-Incurred Injury/Illness <input type="checkbox"/> Professional Development <input type="checkbox"/> Military Caregiver Leave <input type="checkbox"/> Qualifying Exigency Leave	<input type="checkbox"/> Administrative <input type="checkbox"/> Military <input type="checkbox"/> Other (specify): _____	

Requested start date _____	Requested intermittent or reduced work schedules
Anticipated return date: _____	

Do you have UC medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have UC dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have UC optical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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, vacation, or CTO) 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)

_____ Hours/Days of accrued sick	Begins on _____ and ends on _____
_____ Hours/Days of accrued vacation	Begins on _____ and ends on _____
_____ Hours/Days of accrued compensatory time	Begins on _____ and ends on _____
_____ Hours/Days of leave without pay	Begins on _____ and ends on _____

EMPLOYEE'S SIGNATURE:	DATE:	TELEPHONE: ()
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SECTION II – TO BE COMPLETED BY THE UNIVERSITY

APPROVAL/DENIAL OF LEAVE REQUEST

<input type="checkbox"/> Your request for leave is approved and ____ weeks ____ days ____ hours qualify as FM leave under FMLA ____ weeks ____ days ____ hours qualify as FML leave under CFRA ____ weeks ____ days ____ hours qualify as PDL leave under PDLL ____ weeks ____ days ____ hours qualify as (Specify) _____	Begins on _____ and ends on _____ Begins on _____ and ends on _____ Begins on _____ and ends on _____ Begins on _____ and ends on _____
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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

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 _____
CTO _____ 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)

SUPERVISOR OR DEPARTMENT HEAD'S SIGNATURE

NAME (PRINT)	
SIGNATURE	DATE