LEAVE OF ABSENCE (LOA) REQUEST FORM

ALL LEAVE OF ABSENCE REQUESTS MUST BE APPROVED BY THE SUPERVISOR AND HUMAN RESOURCES BEFORE THE LEAVE BEGINS

Employee Name: _____ **Dept.** _____

Position: _____ Supervisor Name _____

Dates of Requested Leave: First Date of Absence: _____ **Date of Expected Return:** _____

Reason for Your Leave of Absence:

☐ **Regular Disability Leave:** This leave may or may not be a FMLA/OFML and/or ADA qualifying leave of absence. Limited to 12 weeks total of absences (continuous or intermittent) during the most recent 12-month period.

- ☐ Medically necessary care of self
  Attach physician's statement that (a) verifies your inability to work and (b) describes the work activities to avoid.
- ☐ Medically necessary care of dependent child, dependent spouse or dependent parent
  Attach physician's statement that verifies the need for care of your dependent child, spouse or parent.
- ☐ Medically necessary care of child, spouse, dependent parent who is a qualified military service member
  Attach physician's statement that verifies the need for care of the qualified military service member.

☐ **Americans with Disabilities Act (ADA) Qualifying Disability Leave**

☐ **Extended Disability Leave:** Limited to14 weeks total of absences (continuous or intermittent) during the most recent 12-month period. May be used only after a Regular Disability Leave ends.

Are you requesting a Family Medical Leave Act qualifying LOA (either FMLA/OFML)? ☐ **Yes** ☐ **No**

To be eligible for FMLA/OFML qualified LOA:

- You need to have at least 12 months of active employment for EOU over the most recent seven calendar years and worked at least 1250 hours for EOU during the 12 months preceding the date of your LOA request.
- The reason for your leave of absence must qualify under FMLA/OFML.
- Please see the next page of this request form for more information about FMLA/OFML qualifying leaves of absence If you are unsure about FMLA/OFML leaves, or your rights under the FMLA/OFML, please request assistance from the HR Department.

Are you requesting a Americans with Disabilities qualifying disability LOA? ☐ **Yes** ☐ **No**

A person has a ADA qualifying disability if (a) the disability is a physical or mental impairment that substantially limits a major life activity and is not temporary in nature; (b) is qualified to perform the essential functions of the job with or without reasonable accommodation; and (c) presents the necessary medical provider authorizations.

☐ **Parental Leave (unpaid):** Birth of a child or placement of a child with you for adoption/foster care. *Please attach physician note with anticipated delivery date, or an adoption verification letter or placement verification court order.*

☐ **Professional Training (unpaid):** *Attach verification of enrollment/approval into course/program, location, dates.*

☐ **Military Leave (unpaid)**: Please a*ttach copy of your orders.*

☐ **Bereavement Leave**: *Please list your relationship to the deceased family member:* _____.

☐ **General Unpaid Leave of Absence** (not disability related). Describe or attach the reason(s) for needing a LOA.

_____

Note: the SEIU labor contract requires Classified employees to request general unpaid leaves of absence at least 60 days in advance of the leave start date.

Options to Use of Paid Leave Benefits

If accrued paid time-off benefits are available, I am requesting to use the following paid time-off benefits:

Note: if your LOA is due to sick/disability then paid sick leave must be used before other paid leave benefits are used.

Paid Sick/Disability	# hours	Paid Bereavement Leave (4 days max.)	# hours
Paid Vacation	# hours	Paid Personal Days	# hours
Other		Other	

IMPORTANT: Rules for Leaves of Absence

FMLA/OFML qualifying disability leaves of absence:

- *If eligible, you are entitled to up to 12 weeks of FMLA/OFML unpaid leave during the most recent 12-month period measured backward from the date of your first FMLA/OFML absence. This first date is: _____/_____/20____.*
- *All paid and unpaid sick/disability related absence(s) and leave(s) taken within the most recent 12 months run concurrently with FMLA/OFML allowable time off and are included in calculating the allowable12 week maximum.*
- *You will be reinstated with the same or equivalent job, pay, benefits, and terms and conditions of employment if you are released to return to active employment by the end of your approved FMLA/OFML leave. Your healthcare insurance benefits will be maintained only during the 12 allowable weeks of your FMLA/OFML approved leave under the same conditions as if you continued to work. You may be required to reimburse the University for its share of health insurance premiums paid on your behalf during your FMLA/OFML leave if you do not return to work following your approved FMLA/OFML leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition to you or a covered military service member which would entitle you to additional FMLA/OFML leave; or 2) other qualifying circumstances approved by the University to be beyond your control.*
- *If the circumstances of your LOA change and you are able to return to work earlier than the date indicated on this form, you are required to provide notification at least two workdays prior to the date you intend to report for work.*

If your absence extends beyond the end of your approved FMLA/OFML leave:

- *You may have fewer or no return to work rights under FMLA/OFML regulations.*
- *The University will generally attempt to return you to work that you are able to perform and for which there is a vacant position for as long as 26 weeks from your first date of disability related absence. Your employment will normally terminate after a total of 26 weeks or longer of disability related absence (either continuously or intermittently) during the most recent 12 month period unless otherwise protected by law.*

I affirm that the information I have provided on this application is accurate and complete. I acknowledge that I will provide the University additional information and documentation as may be requested. I understand that the University is guided by applicable laws, regulations and collective bargaining agreements in regards to returning me to work after my leave of absence has ended.

Employee *Signature*: _____

Employee Name (print): _____ **Today's Date:** _____

HR Department Use Only

Date this LOA Request was received by HR Department: _____

HR Dept. *Signature*: _____ **Print Name:** _____

Note: Administrator signature confirms only the receipt of an LOA request; it does not indicate LOA approval or decline.

Leave Request is: ☐ **Approved** ☐ **Declined** Supervisor Initials _____ HR Dept. _____

Conditions of Approval:

- *While on approved LOA, employee is required to provide to the HR Dept. updated disability status reports and intended date to return to work information every _____ weeks.*
- *Other:* _____

Reason(s) for Decline:

☐ Need more information or missing supporting documentation

_____

Note: Employee requesting the leave of absence has 15 calendar days from receipt of this notice to provide the specified missing information and/or documentation; the LOA request may be denied if the 15 day period expires.

☐ Ineligible for requested leave of absence or all allowable leave of absence is exhausted.

☐ Other _____

Human Resources and Payroll: ☐ Payroll adjustments made ☐ Copy in file ☐ Return date reminder in place