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? ☐ Yes ☐ No

Do you have UC dental insurance? ☐ Yes ☐ No

Do you have UC optical insurance? ☐ 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
_____ Hours of accrued vacation
_____ PFCB (8 weeks max; 70%)

Begins on_____and ends on _____
Begins on_____and ends on _____
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

____ 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 _____
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 _____
Vacation _____hours to be applied Begins on_____and ends on _____
PFCB _____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