PACIFIC UNIVERSITY *Leave of Absence Request*

All leaves of absence must be approved in advance. This form must be completed and returned to the Human Resources office when you request your leave. A leave of absence is not considered official until the Department head gives final approval.

NAME: ____ **DATE:** ____________________

DEPARTMENT: ____

TITLE: ____ **DATE OF HIRE:** ____________

SUPERVISOR or DEPT. HEAD: ____

TYPE OF LEAVE REQUESTED:

_____ **Medical Leave - Employee's Own Serious Health Condition**

If this is a medical leave for yourself, you will be eligible for leave for a period of no more than six months (short term disability) until you have been either released to return to work or qualify for long term disability.

Start date of Leave: ________________________ Return date from leave: ______________

Reason for Medical Leave: ____
(Medical Certification form must be completed by medical care provider.)

_____ **Family Leave - to care for a family member**

If leave is required to care for a family member, this leave will be granted in accordance with the Family and Medical Leave Act of 1993, and will not be granted for longer than 12 weeks in any one year period.

Start date of Leave: ________________________ Return date from leave: ______________

Relationship of employee to family member: ________________________

If a minor child, indicate age: __________

Health condition of family member: ____

_____ **Pregnancy Leave**

If requesting leave for pregnancy, you will be eligible for leave for a reasonable period of time. You will only be paid for the time that Standard Insurance approves your leave. However, this leave will be granted in accordance with the Family and Medical Leave Act of 1993, and will not be granted for longer than 12 weeks in any one year period.

Start date of Leave: ________________________ Return date from leave: ______________

_____ **Parental Leave**

If requesting parental leave for the care of a newborn, newly adopted child, or to assume guardianship of a child, this leave will be granted in accordance with the Family and Medical Leave Act of 1993, and will not be granted for longer than 12 weeks in any one year period.

Start date of Leave: ________________________ Return date from leave: ______________
<u>Complete one of the following:</u>

Anticipated birth date of the newborn: ________________
Anticipated arrival date of the newly adopted child: ___________________________
Anticipated arrival date of the child for whom I will be guardian: ________________

_____ **Compassionate Leave**
You are allowed to take up to 3 days paid leave for compassionate leave.

_____ **Military Leave**

_____ **Personal Leave**

VACATION AND SICK LEAVE:
An employee must use both sick leave and vacation accrual prior to being granted an unpaid medical leave of absence.
I must use accrued vacation. Days available: _______.
I must use accrued sick leave. Days available: _______.

For family, pregnancy, and parental leave, the employee may opt to use sick and/or vacation accruals during the leave.
I plan to use accrued vacation: ___yes ___no. If yes, days available: _______.
I plan to use accrued sick leave: ___yes ___no. If yes, days available: _______.

DATE LEAVE ACTUALLY STARTED: ______________________ ***Please attach time cards to form.***

Employee Signature ____________________________________ Date _____________________

Supervisor Signature ____________________________________ Date _____________________

Department Head Signature ______________________________ Date _____________________

Employees must keep in contact with their department on a regular basis to let the department know your status and your intent to return to work. Arrangements must be made with the Human Resources Department if the leave is unpaid and the employee wishes to continue their medical insurance. Failure to return from a leave of absence on the agreed upon date will result in termination for job abandonment.

To be completed by the employee needing family leave to care for a family member:
State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

____ _____________________
Employee Signature Date