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

Begins on and ends on Begins on and ends on

**APPROVAL/DENIAL OF LEAVE REQUEST**

(MM/DD/YYYY)

(MM/DD/YYYY)

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

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)

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 Extended Sick Leave Vacation

Leave without pay

 hours to be applied

 hours to be applied

 hours to be applied

 hours to be applied

Begins on and ends on Begins on and ends on Begins on and ends on Begins on and ends on

(Attach additional sheets if necessary)

NAME (PRINT)

SIGNATURE

DATE

**DEPARTMENT SIGNATURE**

EMPLOYEE'S SIGNATURE:

DATE:

TELEPHONE:

**SECTION II – TO BE COMPLETED BY THE UNIVERSITY**

**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) Union Business Administrative Care for Injured/Ill Family Member Work-Incurred Injury/Illness Military Pregnancy/Disability Professional Development Other (specify):

Care for Newborn/Placed Child Military Caregiver Leave Date of Birth/Placement Qualifying Exigency Leave

Requested start date

Requested intermittent or reduced work schedules

Anticipated return date:

Do you have UC medical insurance?

Yes No

Do you have UC dental insurance?

Yes No

Do you have UC optical insurance?

Yes No