

LEAVE OF ABSENCE REQUEST

Name (Last)	(First)	(MI)	Hire Date
--------------------	---------	------	------------------

Home Address/ Phone Number (while on leave)

Street _____

City, State, Zip _____

Phone _____

Department	<input type="checkbox"/> MPP <input type="checkbox"/> Represented Unit __	<input type="checkbox"/> Confidential <input type="checkbox"/> Executive
-------------------	--	---

Period of Absence

Beginning: _____

Through: _____

Full-Time (40 hrs/wk)
 Less than full-time
 (indicate proposed working hours) _____

Type of Leave Requested*

<input type="checkbox"/> Medical	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Personal
<input type="checkbox"/> Family Medical Leave (FML)**	<input type="checkbox"/> Military	<input type="checkbox"/> Other (please explain) _____
<input type="checkbox"/> Parental (M/P/A)	<input type="checkbox"/> Educational	_____

Reason for Requesting Leave (attach additional sheet if necessary) _____

Will you be using any accrued leave credits?*** Yes No

<input type="checkbox"/> Personal Holiday	_____ # of Hours Available	
<input type="checkbox"/> Sick Leave	_____ # of Hours Available	Hours as of _____
<input type="checkbox"/> Vacation	_____ # of Hours Available	(date)
<input type="checkbox"/> Holiday Credits	_____ # of Hours Available	

Will you be applying for Non-Industrial Disability Insurance (NDI)? Yes No

Do you intend to maintain and pay for benefits during the unpaid portion of your leave?
If you answer yes to any of the below, please contact HR Services for payment arrangements.

Y	N	Monthly \$ Amount	Total Monthly Amount \$
<input type="checkbox"/>	<input type="checkbox"/>	Medical _____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	Dental _____	
<input type="checkbox"/>	<input type="checkbox"/>	Vision _____	
<input type="checkbox"/>	<input type="checkbox"/>	Group Life _____	
<input type="checkbox"/>	<input type="checkbox"/>	LTD _____	

Employee Signature	Date
Supervisor Signature	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved Date
Department Head Signature	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved Date
Vice Chancellor/Chancellor Signature	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved Date
Human Resource Services Signature	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved Date

* Attach appropriate documentation (eg. active duty order).
 ** Refer to CSU FML Policy. Medical certification is required within 15 days of the leave request. This does not apply to childbirth after pregnancy disability leave.
 *** Employee may be required to exhaust accrued leave credits.

NOTE: This form is NOT to be used for Worker's Compensation (Industry Disability Leaves)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.