DEPARTMENT OF
HUMAN RESOURCES

Medical Application for Leave of Absence without Pay

1.) APPLICANT SECTION			
Name		Employee ID (T#)	Date
Rank or Title	Department		

		Dates requested:	
☐	**Faculty/Non-Classified Employee** Leave not to exceed one year	From:	To:
		Dates requested:	
☐	**Classified Employee** Leave not to exceed six months	From:	To:

I understand that the President may grant an employee's written request for a leave-of-absence without pay not to exceed the limits indicated above for my employee classification unless granted in accordance with the provision for military leave. Leave without pay is not to be granted, except in the case of maternity leave (see Sick Leave), until all of the employee's accumulated annual and sick leave has been exhausted. Any employee on leave-of-absence without pay does not accumulate annual leave nor participate in the group insurance programs to which the University makes a contribution nor receive pay for any legal holidays. An employee may continue with the insurance programs by paying the entirety of those costs, provided arrangements have been made in advance with the Department Human Resource to assume full payment of the premium costs.

Retention of Fringe Benefits
I understand that in order to retain my fringe benefits while I am on leave of absence without pay, it is my responsibility to contact the Department of Human Resources regarding payment procedures. I also understand that failure to pay premiums will result in cancellation of coverage and you will not be able to enroll for coverage unless there is a future HIPAA qualifying event for health and dental; and/or open enrollment for vision insurance (if applicable).

I attest that I am physically unable to work at this time and have exhausted all other leave options.

(Applicant Signature) **(Date)**

2.) HR USE ONLY SECTION

Employee's Current Leave Eligibility Status. Is the employee eligible for any of the following leave categories?

Family Medical Leave (FMLA):	☐ Yes ☐ No	Dates if approved:
Catastrophic Leave:	☐ Yes ☐ No	Dates if approved:
Worker's Compensation:	☐ Yes ☐ No	Dates if approved:
ADA Accommodation:	☐ Yes ☐ No	Dates if approved:
Has employee previously been approved for Medical LWOP?	☐ Yes ☐ No	If yes, give dates:
Is LWOP needed for the dates requested?	☐ Yes ☐ No	If no, give estimated future dates:
Has medical information been provided to HR?	☐ Yes ☐ No	

Comments:

Human Resource Representative (Print Name)	**Signature**	**Date**

3.) ACKNOWLEDGEMENTS AND APPROVAL

Important: This form is invalid without the signature of the University System President.

Direct Supervisor	**Date**	**Vice Chancellor**	**Date**
Department/Unit Head	**Date**	**Chancellor**	**Date**
Dean or Division Chief (if applicable)	**Date**	**President**	**Date**
		Approved ☐	**Denied** ☐