**Leave of Absence Form**

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| --- | --- | --- | --- | --- | --- |
| **employee information** | | | | | |
| **Employee Name (First, Last, Middle Initial)** | | | | | |
| **Home Address** | | **City** | | **State** | **Zip** |
| **Job Title/ Department** | | **Telephone Number**  HOME  CELL | | | |
| **absence information** | | | | | |
| This is a new request.  This is an update to an existing request. | | | | | |
| Requested Start Date: | | Anticipated Return Date: | | | |
| **type of leave** | | | | | |
| Consecutive Leave of Absence | | Intermittent Absence (information required below) | | | |
| *For Intermittent Absences, describe your intermittent or reduced work schedule (e.g., “up to 2-3 sick days a month per doctor”). This must be medically necessary and documented in a current medical certification form from your health care provider.* | | | | | |
| **reason(s) for leave** | | | | | |
| Please indicate the applicable reason(s) for your leave below. A leave of absence may consist of leave with/without. Paid leave may be used in accordance with applicable policy. Paid leave is required to be used prior to any unpaid leave. For the purposes of a disability claim, paid leave must be used concurrently. During leave  Employees Own Serious Health Condition (**not work related**)\*  Care for Ill Parent, Spouse, Child or Domestic Partner\* **\* *For leaves due to your own or a Family Member’s Serious Health Condition, a Medical Certification form is required.***  A completed [Medical Certification](http://www.ucdmc.ucdavis.edu/hr/hrdepts/labor_relations/fmla_kit.html) form is attached.  I will submit a [Medical Certification](http://www.ucdmc.ucdavis.edu/hr/hrdepts/labor_relations/fmla_kit.html) form within 15 days to HR. | | | | | |
| Workplace Injury / Worker’s Compensation | | | | | |
| Pregnancy Leave  Baby Bonding (Care for Newborn/Placed Child) ***°***  ***°*** *Provide the Date of Birth or Placement of Child*: | | | | | |
| Military Leave: Active Duty, Military Caregiver or FML | | | | | |
| Personal Leave (Non-Medical Reason) | | | | | |
| **disability benefits** | | | | | |
| I will file a claim for Disability benefits | | | | | |
|  | | | | | |
| Employee Signature: Date: | | | | | |
| **HR/Supervisor Review** | | | | | |
| Leave of Absence: | Approved | | Denied (See notes) | | |
| FMLA: | Approved | | Denied (See notes) | | |
| STD: | Approved | | Denied (See notes) | | |
| Notes/Comments: | | | | | |
| Supervisor Signature: Date: | | HR Review: Date: | | | |