



Family and Medical Leave of Absence Request

(To confirm dates of leave with pay and without pay.)

To be completed by employee

Employee's Name		Department	Phone Number											
Title			Employee ID											
<input type="checkbox"/> Initial Application		<input type="checkbox"/> Amendment to LOA request (specify date of LOA)												
Reason for Leave of Absence <input type="checkbox"/> Own illness (not work related) <input type="checkbox"/> Care for ill parent/spouse/child <input type="checkbox"/> Work-incurred disability <input type="checkbox"/> Other (specify)		<input type="checkbox"/> Pregnancy disability <input type="checkbox"/> Care for newborn/adopted child (Date of Birth/Placement)	Answer all: Do you have UC medical insurance? Do you have UC dental insurance? Do you have UC optical insurance?	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> <td style="width: 50px;"></td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 50px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> Are you currently on another leave? Have you or will you be filling a University Disability insurance claim?	Yes	No		Yes	No	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Yes	No		Yes	No										
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>										
Requested start date	Anticipated end date	Requested intermittent or reduced work schedule												
<i>A leave of absence is normally a leave without pay. Paid leave (using accrued sick leave, vacation leave, or comp. time) shall be substituted for all or a portion of the unpaid leave in accordance with the appropriate policies/contracts.</i>														
I wish to use paid leave as indicated (attach pages, as needed)			Date Begins (mm/dd/yy)	Date Ends (mm/dd/yy)										
Hours	Accrued sick leave													
	Accrued vacation leave													
	Accrued COMP time (not to be used during FMLA)													
Employee's Signature			Date											

To be completed by department

Your requested leave of absence was approved				
Days	Weeks		Date Begins (mm/dd/yy)	Date Ends (mm/dd/yy)
		Qualify as FMLA leave under Federal law		
		Qualify as California Family Rights Act leave under State law		
		Qualify as Pregnancy Disability leave under State law		
Hours Applied	Pay Status During Leave of Absence		Date Begins (mm/dd/yy)	Date Ends (mm/dd/yy)
	Sick leave			
	Extended sick leave			
	Vacation			
	Leave without pay			
	COMP time (not to be used during FMLA)			
HRMS Code Select either Leave with Pay (PLA) or Leave without Pay (LOA) and enter in the appropriate Reason code	HRMS Action		HRMS Reason	Date Begins (mm/dd/yy)
	PLA <input type="checkbox"/>	LOA <input type="checkbox"/>		
	PLA <input type="checkbox"/>	LOA <input type="checkbox"/>		
	PLA <input type="checkbox"/>	LOA <input type="checkbox"/>		
	PLA <input type="checkbox"/>	LOA <input type="checkbox"/>		
Comments				

Your requested leave of absence was **denied**

Your requested leave for family or medical purposes was **denied** because it does not meet the Federal/State law requirements for the following reasons:

Your requested leave has been **denied** for the following reasons:

Comments

Supervisor's
Signature

Date

Phone number

Department Head's
Signature

Date

Phone number