

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Leave of Absence Request

EMPLOYEE: PLEASE FILL OUT TOP PORTION

Employee:	Phone:	Campus Phone:
-----------	--------	---------------

Department:	Title:	Employee ID:
-------------	--------	--------------

<input type="checkbox"/> Initial Application <input type="checkbox"/> Amendment (Specify date of last LOA request)	<p>Reason For Leave of Absence:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Own Illness (not work related)</td> <td><input type="checkbox"/> Union Business</td> <td><input type="checkbox"/> Administrative</td> </tr> <tr> <td><input type="checkbox"/> Care for Ill Parent/Spouse/Child</td> <td><input type="checkbox"/> Work-Incurred Injury</td> <td><input type="checkbox"/> Military</td> </tr> <tr> <td><input type="checkbox"/> Pregnancy Disability</td> <td><input type="checkbox"/> Furlough</td> <td><input type="checkbox"/> Other (specify)</td> </tr> <tr> <td><input type="checkbox"/> Care for Newborn/Placed Child</td> <td><input type="checkbox"/> Professional Development</td> <td></td> </tr> </table> Date of Birth/Placement: _____	<input type="checkbox"/> Own Illness (not work related)	<input type="checkbox"/> Union Business	<input type="checkbox"/> Administrative	<input type="checkbox"/> Care for Ill Parent/Spouse/Child	<input type="checkbox"/> Work-Incurred Injury	<input type="checkbox"/> Military	<input type="checkbox"/> Pregnancy Disability	<input type="checkbox"/> Furlough	<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Care for Newborn/Placed Child	<input type="checkbox"/> Professional Development	
<input type="checkbox"/> Own Illness (not work related)	<input type="checkbox"/> Union Business	<input type="checkbox"/> Administrative											
<input type="checkbox"/> Care for Ill Parent/Spouse/Child	<input type="checkbox"/> Work-Incurred Injury	<input type="checkbox"/> Military											
<input type="checkbox"/> Pregnancy Disability	<input type="checkbox"/> Furlough	<input type="checkbox"/> Other (specify)											
<input type="checkbox"/> Care for Newborn/Placed Child	<input type="checkbox"/> Professional Development												

Requested start date:	Requested intermittent or reduced work schedules:
Anticipated return date:	

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, vacation, or CTO) shall be substituted for all or a portion of the unpaid leave in accordance with the appropriate policies/contracts.

I wish to use paid leave as indicated below: (attach additional sheets if necessary)

_____ Hours of accrued sick leave	Begins on	_____ MM/DD/YY	and ends on	_____ MM/DD/YY
_____ Hours of accrued vacation	Begins on	_____	and ends on	_____
_____ Hours of accrued compensatory time off (not for use with Family & Medical Leave)	Begins on	_____	and ends on	_____

Employee's signature: _____ Date: _____

DEPARTMENT: PLEASE FILL OUT BOTTOM PORTION

APPROVAL/DENIAL OF LEAVE REQUEST

Your requested leave is approved, and

_____ / _____ days/weeks qualify as FML leave under Federal law	Begins on	_____ MM/DD/YY	and ends on	_____ MM/DD/YY
_____ / _____ days/weeks qualify as FML leave under State law	Begins on	_____	and ends on	_____
_____ / _____ days/weeks qualify as (specify) _____	Begins on	_____	and ends on	_____

Family and Medical Leave

Your requested for family or medical purposes does not meet the requirement under Federal/State law for the following reason(s):

Other Leaves

Your requested leave is not approved for the following reason(s):

PAY STATUS DURING LEAVE

Sick Leave	_____ hours to be applied	Begins on	_____ MM/DD/YY	and ends on	_____ MM/DD/YY
Extended Sick Leave	_____ hours to be applied	Begins on	_____	and ends on	_____
Vacation	_____ hours to be applied	Begins on	_____	and ends on	_____
CTO	_____ hours to be applied	Begins on	_____	and ends on	_____
Leave without pay	_____ hours to be applied	Begins on	_____	and ends on	_____

(Attach additional sheets if necessary.)

Personnel Program or Collective Bargaining Agreement _____ Exempt Non-exempt

Benefits Eligibility: Health Dental Vision

Supervisor's signature: _____ Date: _____ Phone: _____

Department Head's signature: _____ Date: _____ Phone: _____

Leave of Absence Request Form (page 2)
PRIVACY NOTIFICATION

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University to provide the following information to individuals who are asked to supply information.

The principal purpose for requesting the information on this form is to process requests for leaves of absence. The Federal Family and Medical Leave Act of 1993 and University policy authorize maintenance of this information.

Information furnished on this form may be used by various University departments for benefits, payroll and personnel administration, and will be transmitted to the Federal and State governments as required by law.

Individuals have the right to review their own records in accordance with University personnel policy and collective bargaining agreements. Information on applicable policies and agreements can be obtained from campus or Office of the President Staff and Academic Personnel Offices.

The officials responsible for maintaining the information contained on this form are: Campus Departments or Campus Accounting Officers.