SJSU SAN JOSÉ STATE UNIVERSITY

Office of Faculty Affairs

San Jose State University
One Washington Square
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San Jose, CA 95192-0021

TEL: 408-924-2450
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FACULTY UNIT 3 LEAVE OF ABSENCE REQUEST-MEDICAL/PARENTAL

Employee Information

Name First and Last:	Employee ID:	Phone Number:	
Address (Street, City, State, Zip):			
Department Name:	College:	Position Title/Rank:	Current Time Base:
Email Address:	Emergency Contact Name:	Emergency Contact Phone:	
I am requesting (select one)	Full Time Leave:	Partial Leave: at Percent	

Reason For Leave

Employee Medical:	Family Care:	Parental:

Period of Absence

Last Day Worked:	Requested Leave Start Date:	Expected Return to Work Date:

Time Requested (check all you wish to apply. Eligibility and Accruals will be confirmed.)

Parental Leave (select one):	30 working days	40% Workload Reduction	Leave Sharing	Name of spouse/partner:
Sick		Hours Requested:		
Personal Holiday		Days Requested:		
Vacation		Hours Requested:		
Leave Without Pay				

Signatures

My signature below certifies that information relevant to this application for leave is accurate and truthful. I understand any misrepresentation on my part may be cause for denial or rescission of the leave and/or disciplinary action. I understand I will be required to submit appropriate certification related to my leave request.

Employee Signature:		Date:
Chair Signature:	Date:	I have been notified of leave
Dean Signature:	Date:	I have been notified of leave

University Action

Faculty Affairs signature:	Date:
Comments:	Approved Not approved
Date Medical Certification received by HR:	N/A