

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		