



Request for Leave of Absence: Personal Leave

Name Date

University ID Email Address

Status: ☐ Full Time ☐ Part Time

Campus mailing address: Campus Telephone

Home mailing address: Home Telephone

Requested Leave Start Date

Requested Leave End Date OR
Requested Duration of Leave

I require a Personal Leave of Absence due to the following reasons:

☐ **Medical:** If you are requesting a medical leave of absence but are not eligible for FMLA, you are required to submit a Certification of Health Care Provider form. If your leave is approved, it will be counted against your FMLA entitlement. The Health Care Provider form must be submitted only to the Human Resources Department.

☐ **Non-Medical:** Please explain, e.g. family emergency, personal business, below.

Employee Name

Employee Signature & Date _____

Immediate Supervisor Name

Immediate Supervisor Signature & Date _____

Department Head Name

Department Head Signature & Date _____

FOR HR USE ONLY

☐ Approved ☐ PAF Received ☐ Denied & Reason for Denial:

Comments

HR Representative Signature and Date _____