LEAVE OF ABSENCE
For all benefited and non-benefited employees
(Without Pay)

NOTE: If the reason for your leave is medical, please attach an Employee Work Restrictions form.

For benefited employees, leave of absence requests will be granted only after all earned vacation and floating holidays have been used. Employees on leave of absence without pay shall receive pro-rated benefits.

For medical leave, please attach doctor documentation of proof.

EMPLOYEE: _____ DATE: _____

POSITION/TITLE: _____ DEPT: _____

First Day of Leave: _____

Last Day of Leave: _____

Total Expected Time Involved: _____ days

Reason for Leave: _____

_____

_____

I understand that should I wish to continue my insurance coverage during this period of absence, that it will be my responsibility to pay the entire cost on a monthly basis.

I further understand that failure to use this leave for the above stated purpose or failure to report for work on the next work day following expiration of this leave may cause my termination of employment.

By clicking on the employee acceptance button, I certify that the information above is true and accurate.

☐ EMPLOYEE ACCEPTANCE DATE: _____

APPROVED BY

SUPERVISOR: _____ DATE: _____

DEPARTMENT HEAD: _____ DATE: _____

HUMAN RESOURCES DIRECTOR: _____ DATE: _____