



Leave of Absence Request Form

Leave Information

Employee Name: _____ Date of Request: _____
 Employee Number: _____ Department Number: _____ Department Name: _____

Type of Leave Requested:

- Extended Leave with Qualified Medical Certification for Medical Leaves
Check One: Non-FMLA Medical Personal Educational
 - Family Leave with Qualified Medical Certification
Check One: Continuous Intermittent
Check One: Adoption/Placement Birth Employee Medical Family Member
 Military – Parent, spouse, son, daughter or next of kin
 - Military Leave Annual Training Presidential Call Up
 - Parental Leave
Check One: Continuous Intermittent
 - Workers' Compensation – Last Date Worked: _____ Date of Injury _____
- Check One:** Paid Unpaid

Dates of Leave: From: _____ To: _____
 (first day of leave) (proposed or revised return to work date)

Reason:

I understand that if I do not return from my leave of absence at the expiration of this leave, unless prior written approval of an extension has been obtained, my employment may be terminated per the terms of SPP1011 or ACD 707.

 Employee Signature (Print) Employee Signature Date

Supervisor Approval

 Supervisor or Designee Name (Print) Supervisor or Designee Signature Date

Required for all Leave Requests

 Budgetary Approval: (signature of VP, Dean, or Designee) Date

Send to:

- Department Leaves Manager Original
 - Benefits Design & Management Copy
- For Tempe or Polytechnic campus employees: Fax to 480-993-0007 Copy
- For Downtown Phoenix or West campus employees: Mail Code 2051 or Fax to 602-543-8412 Copy