Unpaid Leave of Absence Request Form

An unpaid leave of absence is available in certain circumstances as described in HR 412a. Employees who meet the eligibility criteria for a leave of absence must complete this form at least two weeks prior to the commencement of leave or as soon as practicable in the event of an unforeseeable absence. Please note:

- All leaves of absence must be approved in advance by human resources (HR) and the employee's supervisor.
- If the dates of requested leave change, a new leave of absence request form must be submitted for approval.
- Employees on an unpaid leave of absence are responsible for payment of insurance premiums as agreed upon with HR prior to the commencement of leave.
- Employees returning from a leave of absence must contact HR at least one week in advance of the projected return date.

See HR 412a – Leave of Absence Without Pay (Long-term) for the full details on unpaid leaves of absence, including eligibility.

This form should not be used to request leave under the Family and Medical Leave Act (FMLA) or to request leave as an accommodation under the Americans with Disabilities Act (ADA). Employees should consult with HR to request leave under the FMLA or ADA.

To be completed by the employee:

Date of request: _____ Employee name: _____
Department: _____ Job title: _____
Date of hire: _____

Employee status: ( ) Exempt ( ) Nonexempt ( ) Full time ( ) Part time

Requested leave dates (mm/dd/yy): _____ to _____.

Reason for the leave of absence: _____

_____.

I have read and fully understand the information contained in the Partnership's leave of absence policy.

_____ _____
Employee signature Date

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To be completed by the employee's supervisor:

Leave request is: ____ Approved ____ Not approved

If not approved, provide an explanation: _____

_____.

Supervisor signature: _____ Date: _____

To be completed by HR:

Leave request is: ____ Approved ____ Not approved

If not approved, provide an explanation: _____

_____.

HR employee signature: _____ Date: _____

Employee's last day worked: _____ Employee's return-to-work date: _____

Insurance to be continued and the weekly/monthly cost to employee:

Medical	(X) Yes	( ) No	( ) N/A	_37.49 per pay date_$
Dental	(X) Yes	( ) No	( ) N/A	_1.71 per pay date_$
Other: Vision_____	(X) Yes	( ) No	( ) N/A	_.36 per pay date_$

Total insurance premium due per pay date: $_39.56_____

Note: The Partnership will deduct any cost not paid during the unpaid absence on the first pay date following the employees return unless other arrangements are made.

Total insurance premium due per month: $_____

File original in the employee's leave records and provide a copy to the employee and the employee's supervisor.