Staff Employee Extended Leave Without Pay (LWOP) Request

Employees desiring an extended leave without pay (4 weeks or more) must complete this form and submit it for approval before the leave may be granted. Please type or print neatly and submit the request to your immediate supervisor. If your supervisor and department approves your request submit this form to the Human Resources Department at least ten (10) days prior to the beginning of the leave.

Name: _____ _____ _____ Date of Request: _____
Last First Middle

Department: _____ Position Title: _____

Administrative Unit: Finance ☐ Academic Affairs ☐ Student Affairs ☐ Research ☐ Other ☐

I hereby request an extended leave of absence without pay for the period beginning _____ at _____ p.m./a.m.
month – day - year

through _____ at _____ p.m./a.m. I will return on _____ at _____ p.m./a.m.
month - day - year month - day - year

Total # LWOP work days _____

The reason for my leave is (check one) professional development ☐, extended sick leave ☐, or other ☐ .
I request this leave because:

_____

If your LWOP is less than six months your health and dental insurance coverage will end if you do not self-pay your insurance premiums. If you do not continue your health and dental insurance while on LWOP you will not be covered. When you return to active work you will be required to wait for an open enrollment period to reinstate your coverage.

If your LWOP exceeds six months you may continue your health and dental insurance through COBRA and when you return to active work you need to re-enroll for health and dental insurance.

Your life insurance and long term disability insurance will end unless you qualify and choose to convert them to an individual policy. You will be responsible for paying the premiums directly to the appropriate insurance company. Please contact the Human Resources Department for more information.

I understand that during this leave period I will loose my insurance coverage unless I make arrangements to continue the insurance and make payments to the appropriate agency. I understand I will not accrue sick leave or vacation leave while on LWOP.

_____ _____ NOTE: Please give this request to your immediate supervisor.
Employee's signature Date

I hereby (check one) approve _____ disapprove_____ the requested LWOP with the understanding that the employee (check one) will___ will not___ be reinstated to the same or comparable position within the department. The necessary/proper medical verification is attached.

Other approvals as may be required

_____ _____ _____ _____
Supervisor Date

_____ _____ _____ _____
Appointing Authority Date

I hereby (check one) recommend _____ do not recommend _____ approval of the LWOP as requested.
REMARKS:

_____ _____
Director of Human Resources Date

NOTE: Please return the completed form to the Human Resources Department. Revised 8/31/00