Employee 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 the supervisor and appointing authority approves the 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

Department: _____ Position Title: _____

I hereby request an extended leave of absence without pay for the period beginning _____
MM/DD/YY

through _____ . I will return on _____ . Total #LWOP work days: _____
MM/DD/YY MM/DD/YY

Reason for request:

I understand that:

- I may continue my health and dental insurance through COBRA and when I return to active work I need to re-enroll for health and dental insurance.
- My life insurance and long term disability insurance will end unless I qualify and choose to convert them to an individual policy. I will be responsible for paying the premiums directly to the appropriate insurance company.
- During this leave period I will lose my insurance coverage unless I make arrangements to continue the insurance and make payments to the appropriate agency. I will not accrue sick leave or vacation leave while on LWOP.

_____ _____
Employee 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.

_____ _____
Supervisor signature Date

_____ _____
Appointing Authority signature Date

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

REMARKS:

_____ _____
Assoc VP of Human Resources Date

NOTE: Please return the completed form to the Human Resources Department. Revised 9/8/11