# LEAVE OF ABSENCE REQUEST

FOR DEPARTMENT USE ONLY: Personnel Program or Collective Bargaining Agreement:

## SECTION I – TO BE COMPLETED BY THE EMPLOYEE

| EMPLOYEE'S NAME | TELEPHONE | CAMPUS |
|---|---|---|
| | | UCSD |
| DEPARTMENT | TITLE | EMPLOYEE ID |
| | Resident Physician | |

☑ Initial Application

☐ Amendment to LOA that began on _____

Requested start date _____

Anticipated return date: _____

**Reason for Leave of Absence:**

- ☐ Own Injury/Illness (not work-related)
- ☐ Care for Injured/Ill Family Member
- ☐ Child Bearing/Disability 1st 6 to 8 Weeks
- ☐ Parental Bonding/Care for Newborn 2nd 4 to 6 weeks
  Date of Birth/Placement _____
- ☐ Paid Parental Bonding Leave (PPBL)
- ☐ Qualifying Exigency Leave
- ☐ Work-Incurred Injury/Illness
- ☐ Professional Development
- ☐ Military Caregiver Leave
- ☐ Administrative
- ☐ Military
- ☐ Union Business
- ☐ Other (specify):

Requested intermittent or reduced work schedules

| Do you have UC medical insurance? | Do you have UC dental insurance? | Do you have UC optical insurance? |
|---|---|---|
| ☑ Yes ☐ No | ☑ Yes ☐ No | ☑ Yes ☐ No |

Have you or will you be filing a University Disability Insurance claim? ☐ Yes ☑ No

**A leave of absence is normally leave without pay. Paid leave (accrued sick leave or vacation) may be substituted for all or a portion of the unpaid leave in accordance with appropriate policies/contracts.**

☐ I wish to use paid or unpaid leave as indicated below: (attach additional sheets if necessary)

| | (MM/DD/YYYY) | (MM/DD/YYYY) |
|---|---|---|
| _____ Days of accrued sick requested | Begins on _____ | and ends on _____ |
| _____ Days of accrued vacation requested | Begins on _____ | and ends on _____ |
| _____ Days requested for Leave Without Pay | Begins on _____ | and ends on _____ |
| _____ PPBL | Begins on _____ | and ends on _____ |

**EMPLOYEE'S SIGNATURE:** DATE:

## SECTION II – TO BE COMPLETED BY THE UNIVERSITY

### APPROVAL/DENIAL OF LEAVE REQUEST

☑ Your request for leave is approved

| | (MM/DD/YYYY) | (MM/DD/YYYY) |
|---|---|---|
| ____ weeks ____ days ____hours qualify as FM leave under FMLA | Begins on _____ | and ends on _____ |
| ____ weeks ____ days ____hours qualify as FML leave under CFRA | Begins on _____ | and ends on _____ |
| ____ weeks ____ days ____hours qualify as PDL leave under PDLL | Begins on _____ | and ends on _____ |
| ____ weeks ____ days ____hours qualify as (Specify)_____ | Begins on _____ | and ends on _____ |

Family and Medical Leave

☐ Your request for FML is not approved for the reasons set forth on the Designation Notice.

Other Leaves

☐ Your requested leave is not approved for the following reason(s):

_____

### PAY STATUS DURING LEAVE

| | | (MM/DD/YYYY) | (MM/DD/YYYY) |
|---|---|---|---|
| Days Accrued Sick | _____ Days to apply | Begins on _____ | and ends on _____ |
| Days Accrued | _____ Days to Apply | Begins on _____ | and ends on _____ |
| Leave Without Pay | _____ Days to Apply | Begins on _____ | and ends on _____ |
| PPBL | _____ Days to Apply | Begins on _____ | and ends on _____ |

(Attach additional sheets if necessary)

### DEPARTMENT SIGNATURE

NAME (PRINT)

| SIGNATURE | DATE |
|---|---|
| | |