Request for Leave of Absence

University of San Diego

Submit completed form to your department and Human Resources at least 30 days in advance if the leave is foreseeable, or as soon as possible.

Personal Information

Name: _____ Employee ID # _____

Address While on Leave: _____ Ph #: _____

Status ***(check one):*** ☐ Administrative ☐ Faculty ☐ Staff Personal email: _____

Last day worked: _____ Requested start date of leave: _____ Anticipated return date: _____

What are your normal days off: M T W TH F S Sun
Do you participate in the Dependent Care Flexible Spending Account (DCFSA)? _____

Reason for Leave ***(Attach supporting documentation, or provide within 15 days of leave request)***

Pregnancy (check all that apply)
☐ Disabled due to pregnancy (**Estimated Due Date**: _____)
☐ Request leave to bond with newborn child immediately following pregnancy disability period

Medical (check all that apply)
☐ Unable to work due to own serious health condition
☐ Intermittent medical leave or a reduced leave schedule, due to own serious health condition
(Check here only if you will continue working; however, on a reduced/intermittent schedule)

Family (check all that apply)
☐ Bonding with newborn child (**Estimated Due Date:** _____ ***or*** **Date of Birth** _____**)**
☐ Placement of child for adoption/foster care (**Date of placement:** _____)
☐ Care for ☐spouse, ☐child, ☐parent, or ☐registered domestic partner with a serious health condition
☐ Intermittent family leave or a reduced schedule to care for a seriously ill family member
(Check here only if you will continue working; however, on a reduced/intermittent schedule)

Other
☐ Personal Leave Reason: _____
☐ Military Leave (Attach or provide orders and LES)
☐ Jury Duty (Attach copy of summons and provide Jury Duty timesheets)
☐ Bereavement
☐ Workers' Compensation

Vacation Authorization ***(Staff & Administrative Employees Only)***
☐ Yes, use my vacation, if necessary, while I am on leave ☐ No, do not use my vacation while I am on leave

I certify that the information provided above is correct. If I am requesting leave due to my own serious health condition, I authorize my healthcare provider to release information to establish my eligibility for a Medical or Pregnancy Disability leave. **I understand the terms and conditions of this leave of absence as set forth in the university's policy manual.**

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

HR Use Only

☐ **FMLA/CFRA** ☐ **FMLA/PDL** ☐ **PDL Only** ☐ **Non FMLA** ☐ **Paid LOA** ☐ **Unpaid LOA** ☐ **SDI** ☐ **PFLI**

DOH: _____ **Salary Continuation End** ***(faculty/admin)*****:** _____