Section I: TO BE COMPLETED BY THE EMPLOYEE

Employee Name: ________________________________________________
Employee PLU ID: ______________________________________________
Department: ____________________________

Effective Dates:
Beginning Date: ___________________________ End Date: ________________________

For Staff and Administrators:
[ ] With pay using accumulated sick and/or vacation leave.
   (FMLA policy states that sick and vacation leave must be used before leave is without pay.)
[ ] Without pay.

Reason for Requesting Leave:
[ ] Employee's health
[ ] Maternity/paternity leave (including adoption)
[ ] To care for an ill family member
[ ] Military exigency
[ ] To care for an injured servicemember
[ ] Other, please explain:

Employee's Signature: ___________________________ Date: ______________

Section II: TO BE COMPLETED BY DEPARTMENT HEAD

I recommend that this leave request be:
[ ] Approved.
[ ] Approved conditionally. (If checked, please indicate conditions below.)
[ ] Denied.

A physician's certificate is required for all medical leaves including maternity/paternity leave. Certificate or other necessary documentation is attached:
[ ] Yes.
[ ] No.

Comments or Conditions of Approval:

Department Head/Officer Signature: ___________________________ Date: ______________

*** Please retain a COPY of this form for your records and forward the ORIGINAL to the Human Resources office.***

Section III: TO BE COMPLETED BY HUMAN RESOURCES

Leave Approved By: ___________________________ Date: ______________

For personal Leave Only: _____With Benefits _____Without Benefits

Updated 1/16/2009