



EXTENDED LEAVE OF ABSENCE REQUEST FORM

Name (Please print)

Position/Assignment

Building

Type(s) of extended leave requested: check below

Sick Leave (two weeks or more) _____

Family Medical Leave (FMLA) _____

Child Rearing Leave (CRL) _____

Leave Without Pay (LWOP) _____

Sabbatical Leave for Restoration of Health _____

Sabbatical Leave for Professional Development _____

Period to be covered by this extended leave request:

Beginning date of leave: _____
MM/DD/YYYY

Expected date to return to work: _____
MM/DD/YYYY

Please indicate the type of leave and the number of days to be used:

Sick Days: _____ Personal Days: _____ Conditional Days: _____ Vacation Days: _____

FMLA Days: _____ CRL Days: _____ LWOP Days: _____

Other (explain):

Date

Signature of Applicant

No one is permitted to return to work without authorization from Human Resources.