MT. DIABLO UNIFIED SCHOOL DISTRICT

1936 Carlotta Drive | Concord, California 94519-1358
(p): (925) 682-8000
www.mdusd.org

CLASSIFIED Request for Leave of Absence Without Pay

Employee Name (print): _____ Employee ID: _____
Job Title: _____ Site Location/Dept: _____
Employee E-mail: _____ Phone Number: _____
Supervisor Name (Print): _____
Supervisor E-mail Address: _____

I hereby request a leave of absence without compensation from active service under the conditions as outlined in my respective Bargaining Unit agreement:

- ☐ Improvement of Health (Medical Note REQUIRED and submitted to HR)
- ☐ General Leave Of Absence
- ☐ Unpaid Leave following PDL
- ☐ Unpaid Leave following Parent Bonding

[Date] First Day Unpaid: _____ [Date] Return to Work: _____
Provide any additional information or relevant context you wish to share regarding your leave:

Submit request 30 days prior to leave.

It is my understanding that this is an Unpaid Leave of Absence (LWOP). I have read the applicable contract rules and regulations and understand the provisions. I understand that it is my responsibility to notify Human Resources of any change to my leave. If I do not communicate changes in a timely manner, I may be considered to have resigned from leave. ***Note:*** Unpaid leaves of more than 30 days may impact the district contributions to your benefit premium. For more information please reach out to the benefits team at benefits@mdusd.org.

_____ _____
Employee Signature Date

Supervisor/Department Head Recommendation (circle or check box)

- ☐ APPROVED
- ☐ NOT APPROVED

_____ _____
Supervisor Signature / Date Reason (if not approved)

For Human Resources Office Use Only (circle or check box)

- ☐ APPROVED
- ☐ NOT APPROVED

_____ _____
HR Representative Signature / Date [1] Reason (if not approved)

[1] Updated 8/2025 (ac)