

Leave of Absence Request Form

Employee Information

HR Approved

Last Name	First Name	J#	Home Phone #	
Mailing Address		City	State	Zip Code
Email Address		Supervisor's Name		Department's Title

Leave Information

Leave Start Date ____/____/____	Leave End Date ____/____/____
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Apply for FML	Apply for On-The -Job (OJI) Wage Replacement Benefits
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Select One <input type="checkbox"/> New Leave <input type="checkbox"/> Continuation of Leave	Select one: Intermittent FML? <input type="checkbox"/> Yes <input type="checkbox"/> No
Select Type of Leave <input type="checkbox"/> FML Employee' s Illness	

I understand that beginning with the fifth calendar day following the day of the incident the On-The-Job Injury Program will pay 66 2/3% of my regular rate of pay for time/wages lost as a result of an on-the-job injury and that this benefit is subject to all normal deductions (such as federal and state tax). I can supplement this reduced rate of pay with my accrued sick and vacation hours.

If lost time resulting from an on -the-job injury exceeds two calendar weeks, the employee must apply for a leave of absence (FML, if eligible or Personal Leave) retroactive to the date of the injury. A new form must be submitted. A leave of absence and onthe-job injury leave will run concurrently and will not "stack" one after the other.

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How to complete this form:

This form is for University General Division employees. If you are a USAHealth employee please complete the PTO Leave of Absence Request form.

Under *Employee Information*, enter your contact information. Do not leave any section