UMASS **University of Massachusetts**

Leave of Absence Request Form

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Employee Name _____ Employee ID _____
(Last) (First) (MI)

Department _____ Department ID _____

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I am requesting a leave of absence for the reason so designated. It is my intention to return to work at the end of the leave period.

Requested Leave Dates

Leave Begin Date [Month Day Year] Leave End Date [Month Day Year]

Please check one in each category:

Leave Reason	**Leave Type**	**Time Requested**
☐ Birth or Adoption	☐ Continuous	☐ Days
☐ Care of Child	☐ Intermittent	☐ Hours
☐ Care of Parent	☐ Reduced Schedule	☐ Weeks
☐ Care of Spouse		
☐ Employee Illness		

This leave is for birth, adoption, foster care placement, care of family member or employee illness and I intend to file for PFML (paid family medical leave)? Yes ☐ No ☐

If this leave qualifies for PFML/FMLA, I understand that I will be reinstated to my same position, or an equivalent position, with equivalent pay, benefits and other employment terms and conditions. I also understand that if I file a claim under PFML and it is approved, that I may use my own accruals during the 7-day waiting period and not at any other time during my approved PFML.

I also understand that failure to return from the approved PFML/FMLA within the agreed upon time frame may constitute a voluntary termination.

I have read the PFML/FMLA Leave policy and the other appropriate policy(ies) specific to my absence and am aware of my responsibilities.

LEAVE WILL BE PAID BY DFML (DEPARTMENT OF FAMILY AND MEDICAL LEAVE) ONLY IF EMPLOYEE APPLIES FOR AND IS APPROVED FOR PFML. IF NOT PFML, LEAVE WILL BE PAID ONLY IF EMPLOYEE HAS SUFFICIENT AND APPROPRIATE ACCRUALS TO COVER PART OR ALL OF THE ABSENCE.

Employee Signature▸ _____ **Request Date▸** _____

Supervisor/Department Head▸ _____ **Date▸** _____

Human Resources Representative▸ _____ **Date▸** _____