

PERSONAL INFORMATION *Faculty/Staff Member to return completed form to supervisor/department chair.*

Last Name:		First Name:	Middle Name:
UMID:	Department:		Title of Position:

LEAVE OF ABSENCE INFORMATION:

Date of Request:	Department Address:	Supervisor's/Department
Supervisor's/Department Chair's Name:		Supervisor's/Department Chair's Signature:

FACULTY/STAFF MEMBER: Check the type of leave, supply the required information in writing, and provide attachments as indicated. Reference Standard Practice Guide 201.30 and 201.30-1, Leaves of Absence. **NOTE: Faculty and Staff represented by a Union should refer to the collective bargaining agreement that governs the terms and conditions of their employment for information regarding leaves of absence.**

Leaves applicable to faculty and staff:

<input type="checkbox"/>	Child Care	State the date of the child's birth, adoption, or foster placement. Date: _____
<input type="checkbox"/>	Educational	Indicate school and credit hours. If not a UM student, attach a completed Educational Leave of Absence Addendum, available at http://www.hr.umich.edu/hrris/forms/pdfs/edleavead2.pdf , to verify registration.
<input type="checkbox"/>	Family Care	Attach U.S. Department of Labor Certification of Health Care Provider For Family Member's Serious Health Condition (Family and Medical Leave Act), Form WH-380-F (http://www.dol.gov/whd/forms/).
<input type="checkbox"/>	Government Service	Indicate the nature and duration of the government service.
<input type="checkbox"/>	Intergovernmental Personnel Assignment	Attach OF69 Assignment Agreement. (Refer to SPG 201.30-5, Federal Personnel Agreements.)
<input type="checkbox"/>	Military Service	Attach a copy of the Notice of Induction or Authorization for Active Duty.
<input type="checkbox"/>	Qualifying Exigency	Attach a copy of the U.S. Department of Labor Certification of Qualifying Exigency For Military Family Leave (Family and Medical Leave Act), Form WH-384 (http://www.dol.gov/whd/forms/).
<input type="checkbox"/>	Care of a Covered Servicemember	Attach a copy of the U.S. Department of Labor Certification for Serious Injury or Illness of Covered Servicemember - for Military Family Leave (Family and Medical Leave Act), Form WH-385 (http://www.dol.gov/whd/forms/).
<input type="checkbox"/>	Personal Medical	If receiving Workers' Compensation, indicate whether you want to exhaust your vacation time before the leave begins.
<input type="checkbox"/>	Medical/Child Care	Provide the date of the child's birth. Date: _____ This leave is only applicable to employees not eligible for extended sick time.
<input type="checkbox"/>	Phased Retirement	Use this form to initiate a phased retirement program. Describe the arrangement for the phased retirement program. (Refer to SPG 201.83, Retirement.)
<input type="checkbox"/>	Personal	State the reason for requesting the leave: _____
<input type="checkbox"/>	Seasonal Leave	Use this form to establish the initial seasonal leave period. (Refer to SPG 201.30-3, Seasonal Leave of Absence Appointment.)

Leaves applicable to faculty members only:

<input type="checkbox"/>	Duty Off-Campus	Indicate the location and duties to be performed. (Refer to SPG 201.90, Duty Off-Campus.)
<input type="checkbox"/>	Outside Teaching Assignment	Indicate the name of the educational institution and the duties to be performed.
<input type="checkbox"/>	Research	State the nature of the research program, the location, and the funding source.
<input type="checkbox"/>	Phased Retirement Furlough	Indicate specific plans and effective date of combined retirement furlough and phased retirement plans. (Refer to SPG 201.81, Retirement Furlough and SPG 201.83, Retirement.)
<input type="checkbox"/>	Retirement Furlough	Indicate specific plans and effective date of complete retirement. (Refer to SPG 201.81, Retirement Furlough.)
<input type="checkbox"/>	Scholarly Activity	State the nature of the activity, the location, and the funding source. (Refer to SPG 201.30-4, Scholarly Activity Leave.)

I request that my leave begin on _____ and end on _____. (If necessary, give approximate dates.)
 I understand that returning to work before the leave's expiration date is at the discretion of the University. **NOTE:** Assuming that I have an eligible appointment upon my return from leave, I authorize the University to automatically re-enroll me (and my dependents, if applicable) in those Benefits Plans in which I was enrolled as of my last day of work (prior to the leave) and to deduct any resulting costs from my earnings. My most recent beneficiary designation for Group Life insurance will be continued.

Office Phone:	Faculty/Staff Signature:
Home Phone:	Home Address:

SUPERVISOR/DEPARTMENT ADMINISTRATOR/HR - Please use this form to indicate leave type and length of leave. Complete all required information (if applicable) in writing and provide attachments as indicated.

Name (Last, First, Middle):	UMID:
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Date Paid Time Ends: _____ *Note: Verify last day of pay with timekeeper or payroll representative for staff members only.*

Leave Information	Pmod:
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Begin Date:	End Date:	Leave Type:
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Is a portion of this leave covered under FMLA?	Yes	No	FMLA PMOD:
If yes, list dates covered under FMLA below.			

Paid Begin Date:	Paid End Date:	Unpaid Begin Date:	Unpaid End Date:
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If FMLA leave is more than 12 weeks, indicate reason and/or comments below.

Please indicate date employee was notified of FMLA status or attach copy of notification letter. Date: _____

Notification Letter Attached: Yes No

Extension of Leave	Pmod:
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Extension Begin Date:	Extension End Date:	Leave Type:
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Authorization

Contact/Preparer Name:	Phone:
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Contact/Preparer Signature:	Date:
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HR Rep Name:	Phone:
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HR Rep Signature:	Date:
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FOR HRRIS USE ONLY

Empl Rcd#	Effdt	Eff Seq	Act/Reason