

UCSF Medical Center Leave of Absence Form

EMPLOYEE: PLEASE COMPLETE THIS PAGE

Employee:	Home Phone:	Work Phone:
Department:	Title:	ID #

TYPE OF ACTION Leave of Absence <input type="checkbox"/> Initial Leave Application <input type="checkbox"/> Extension of Leave <input type="checkbox"/> Return from Leave Date Returned _____	LEAVE TYPE <input type="checkbox"/> Own illness (not work related) <input type="checkbox"/> Care for newborn/placed child <input type="checkbox"/> Work Related Injury <input type="checkbox"/> Personal, non-FMLA <input type="checkbox"/> Care for Ill Family Member <input type="checkbox"/> Pregnancy Disability <input type="checkbox"/> Military Leave
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This section of the LOA form should be completed for reduced work schedules and intermittent leaves only. Documentation from a health care provider is required for all modifications to an employees normal work schedule.

Please provide your reduced work schedule : Begin Date: _____ End Date: _____ Recommended Schedule: _____ _____	Please provide your intermittent work schedule : Begin Date: _____ End Date: _____ Recommended Schedule: _____ _____
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This section of the LOA form should be completed if you will be off work for longer than 5 days.

Last Day Worked: _____	Anticipated Return Date: _____
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**For Workers Compensation Leaves Stop Here
You will be mailed an additional packet to make payroll elections**

My Disability Waiting Period is: 7 day 30 days 90 days 180 days

A leave of absence is normally a leave without pay. Accrued Sick/Vacation or Paid Time Off /Extended Sick Time (PTO/EST) may be substituted for all or a portion of the unpaid leave **in accordance with the appropriate policies/contracts.** Compensatory Time Off (CTO) may only be used in non-FMLA leaves.

Please check ONE election (if applicable)

I accrue sick and vacation	I accrue PTO & EST
Employees are required to use accrued sick leave, if available, up to 30 calendar days regardless of the current waiting period.	Employees under the PTO program are required to use 3 days of PTO prior to using EST.
<input type="checkbox"/> I authorize the use of my vacation if I don't have enough sick time to cover my disability waiting period. <input type="checkbox"/> I authorize the use of all of my sick time. (maximum use of sick time for family care is 30 days) <input type="checkbox"/> I authorize the use of all of my sick and vacation time. <input type="checkbox"/> I would like access to my Health FSA account during my approved FML time. I will provide the required UPAY 850 form to finalize this election (For a personal leave, only vacation apply)	<input type="checkbox"/> I authorize the use of additional PTO if I don't have enough EST to cover my disability wait period. <input type="checkbox"/> I authorize the use of all of my EST. (maximum use of sick time for family care is 30 days) <input type="checkbox"/> I authorize the use of all of my EST and PTO. <input type="checkbox"/> I would like access to my Health FSA account during my approved FML time. I will provide the required UPAY 850 form to finalize this election. (For a personal leave, only PTO apply)

For Pregnancy Leave Only:

I understand that even if I am not adding my newborn to my benefits, that I must notify the benefits office of my delivery date and type for coordination of continued UC contributions to my medical, dental and vision plan

Employee Signature (if available)	To correspond by email during your leave please provide an email address	Date
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Employee: _____

DEPARTMENT MANAGER: PLEASE COMPLETE THIS SECTION		
NOTE: Must use the employee's directions on page one as a guideline for keying hours/paying your employee while on leave. This will be processed promptly according to payroll deadlines and in accordance with University Payroll Policies and Collective Bargaining agreements. By signing this form you are acknowledging the leave dates of your employee.		
Manager signature required to process paperwork for all leave types: _____	Phone number: _____	Box Number: _____
Manager Printed Name: _____	Department: _____	Date: _____
HR/BENEFITS DEPARTMENT:		
Notice of FMLA entitlement will be processed once the certification from the medical provider has been received and reviewed		
BENEFITS/PROCESSING: PLEASE COMPLETE THIS SECTION		
Leave Representative:	Date:	
Processed by:	Date:	

**Complete and submit to the
Leave Management Department
At Box 1795
Fax to: 415-353-9639
Email to: mcloa@ucsf.edu**