THE UNIVERSITY OF ALABAMA IN HUNTSVILLE

Request for Leave of Absence Form

Please complete and return this Form to your immediate supervisor 30 days in advance of Leave, if possible. ***SEND COMPLETED FORM TO HR.***

☐ Faculty
☐ Staff

EMPLOYEE INFORMATION

Employee Name			**A #**
Home Address	**City**	**State**	**Zip**
Job Title / Department	**Telephone Number** ☐ Home ☐ Cell		
Campus Email			
Reason for Leave Request (If necessary, attach additional sheet)			
Requested Start Date	**Anticipated Return Date**		

TYPE OF LEAVE

☐ **General Leave of Absence (Not to exceed 6 months)**	☐ **Medical Leave of Absence (Not to exceed 6 months)**
* **GENERAL LEAVE OF ABSENCE** Leave for personal reasons may be granted to full-time employees with a year or more of continuous regular service. General leave is without pay. Normally, all accrued vacation and/or sick leave (if applicable) must be exhausted before a general leave of absence begins; however, an employee may request to take such leave without affecting accrued leave account balances.	* **MEDICAL LEAVE OF ABSENCE** Leave for reasons of prolonged illness or other justifiable medical conditions may be granted to full-time employees with a year or more of continuous regular service. Medical leave is without pay. Available sick and vacation leave should be utilized before medical leave begins. A one-time extension, not to exceed 6 months, may be granted on a case-by-case basis with appropriate medical certification. The total amount of time an employee can be on an approved medical leave of absence is one (1) year.

**The determination process includes consideration of factors such as the duration of leave requested, the workload of the department, and the ability to reassign the employee's duties.*

A completed ***Medical Certification*** *form is required to support a Medical Leave of Absence request.*
Click on the hyperlink or contact HR to obtain the form. (click here for form)

☐ **A completed Medical Certification form is attached**
☐ **I will submit a Medical Certification form within 5 days to Human Resources**

Employee Signature: _____ **Date:** _____

APPROVALS

Immediate Supervisor / Dept. Chair:	**Director / Dean:**	**Vice President:**
Date:	**Date:**	**Date:**
☐ **Approved** ☐ **Submit ePAF** ☐ **Not Approved**	☐ **Approved** ☐ **Approve ePAF** ☐ **Not Approved**	☐ **Approved** ☐ **Approve ePAF** ☐ **Not Approved**