**TEXAS WOMAN’S UNIVERSITY**

REQUEST FOR EXTENDED LEAVE WITHOUT PAY

PART I: TO BE COMPLETED BY EMPLOYEE

Complete the request and forward it to Human Resources. The request will not be considered without all required signatures on the application.

Employee Name: Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor Name : Dept: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR LEAVE:**

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Date leave without pay is requested to begin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date you plan to return to work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I must exhaust all available accrued sick leave, vacation leave, comp time, and overtime before Leave Without Pay is allowed to begin. I understand that in most cases, Leave Without Pay must be FMLA-covered to be considered approved leave.

I acknowledge that if I do not return from extended leave without pay for at least 30 calendar days, that **I am required to pay ERS directly for all insurance premiums during any month that is full unpaid** leave. If premiums are not paid to ERS as directed by ERS, insurance coverage will be canceled the first of the month following the exhaustion of paid leave.

**Employee Signature:**

I attest that the information noted above is true and accurate to the best of my knowledge and that I have full intention of returning to work. I understand that I am responsible for obtaining information from my health care provider to provide additional or clarifying information that would assist in the determination of my qualifying for this request. In compliance with HIPAA Medical Privacy Rules, my signature indicates my permission for the health care provider to release any and all information as requested on this form for clarification of individually identifiable health information.

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 Employee’s Signature Contact Phone Number Date

PART II: TO BE COMPLETED BY ALL INDICATED LEVELS OF MANAGEMENT

I acknowledge this employee’s request for extended Leave Without Pay. I have reviewed the applicable TWU Policy 3.28 for Staff Leave of Absence and Leave Without Pay, and recommend that this application be forwarded to the next proper administrator, in the order listed, for determination.

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 Supervisor’s Signature Supervisor’s Name Date

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 VP or Provost’s Signature VP or Provost’s Name Date

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Sr. AVP for Human Resources’ Signature Sr. AVP for Human Resources’ Name Date

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 Chancellor’s Signature Date

Please return to the Office of Human Resources for determination that the request meets criteria for extended Leave Without Pay.