Human Resources
csumb.edu/hr
leaves@csumb.edu

REQUEST FOR FORMAL LEAVE OF ABSENCE

INSTRUCTIONS: A leave of absence is defined as time away from work in excess of five consecutive workdays, excluding pre-approved vacation time. If you are represented by a collective bargaining agreement (CBA), please review the leave provisions in your CBA. For assistance in completing this form, preparing a leave calendar, by emailing leaves@csumb.edu. After completing this form, submit it to *leaves@csumb.edu*. A leaves analyst will route this for all applicable signatures and pay processing via adobesign.

EMPLOYEE INFORMATION ☐ FACULTY ☐ STAFF

EMPLOYEE ID	FIRST NAME	LAST NAME	CAMPUS EXT

DEPARTMENT	MANAGER'S NAME AND EXTENSION

CONTACT INFORMATION WHILE ON LEAVE

PHONE	PERSONAL EMAIL	MAILING ADDRESS

LEAVE OF ABSENCE INFORMATION *(Complete all sections)*

Action:
- ☐ NEW
- ☐ CHANGE
  - NEW START DATE
  - NEW END DATE
- ☐ CANCEL

Leave type:
- ☐ MEDICAL
- ☐ FML SELF
- ☐ FML FAMILY
  - RELATIONSHIP: _____
- ☐ PARENTAL/ADOPTION/FOSTER[1]
- ☐ ORGAN/BONE MARROW DONOR

1 Medical certification required

- ☐ EMERGENCY
- ☐ MILITARY[2]

ADMINISTRATOR OR PROVOST APPROVAL REQUIRED:
- ☐ PERSONAL
- ☐ EDUCATIONAL
- ☐ PROFESSIONAL*

** Faculty only*

2 Attach copy of orders and other evidence as required

LEAVE CREDITS *(Leave balances can be viewed in CMS)*

SICK _____ HRS VACATION _____ HRS CTO _____ HRS

PERSONAL HOLIDAY _____ DAY WILL YOU BE APPLYING FOR NDI? ☐ YES ☐ NO

WILL YOU BE APPLYING FOR CATASTROPHIC LEAVE SOLICITATION? ** ☐ YES ☐ NO

*** If yes, all leave credits must be exhausted to be eligible for catastrophic leave payand the employee must be deemed "totally Incapacitated" by the medical provider*

PERIOD OF ABSENCE *(Check All that Apply)*

☐ **Full:**

LAST DAY WORKED FIRST DAY OF LEAVE RETURN-TO-WORK DATE

☐ **Partial:**

START DATE END DATE RETURN TO FULL-TIME DATE

Attach Work Schedule

☐ **Intermittent:**

START DATE INTERMITTENT END DATE RETURN TO WORK DATE

Attach Work Schedule

☐ **Leave without Pay (LWOP)** *4*:

START DATE RETURN TO WORK DATE HOURS WORKED PER WEEK

LWOP Benefits to be Paid Out of Pocket *4*:

Medical ☐ Dental ☐ Vision ☐ Group Life Insurance ☐ Long-term Disability ☐

4 Unless the leave falls under the Family Medical Leave Act, the following conditions apply: while on leave, if an employee's salary is insufficient to cover benefits, the employee may lose all health, vision, and dental benefits. Please discuss with HR for possible salary implications and options. Unit 3 CBA Article 22.8: Faculty unit employees on a personal leave without pay shall not accrue service credit toward probation, sabbatical eligibility, difference in pay eligibility, service salary increase eligibility, or seniority except as provided in provisions 22.22 and 22.23 of this article. Unit 3 CBA Article 22.7: a faculty unit employee on a leave of absence without pay shall notify the appropriate administrator no later than April 1 of their intention to return to duty at the beginning of the academic year or no later than October 1 of their intention to return to duty at the beginning of the spring term or winter quarter. rev 4/28/2023

EMPLOYEE CERTIFICATION:

My signature indicates that information relevant to this application for leave is accurate and truthful. I understand the terms and conditions of leaves and request Leave for the reasons provided. I understand that any misrepresentation on my part may be cause for denial or rescission of the leave and/or disciplinary action. I understand I will be required to submit appropriate certification related to my leave to my manager (staff) or department chair (faculty) and HR prior to resuming work.

EMPLOYEE SIGNATURE: **DATE:**

RECOMMENDATIONS AND APPROVALS:

I have discussed this request with the employee, consulted with HR, and understand that final eligibility and approval for medical and family-related leaves is determined by HR.

LEAVES OF ABSENCE *(Medical, Parental, Family Care, etc.):*

(STAFF) ADMINISTRATOR'S SIGNATURE: **DATE:**

(FACULTY) DEAN'S SIGNATURE: **DATE:**

(FACULTY) DEPARTMENT CHAIR'S SIGNATURE: **DATE:**

(FACULTY) PROVOST'S SIGNATURE: **DATE:**

LEAVES OF ABSENCE *(Personal, Educational, and Professional):*

(STAFF) ADMINISTRATOR'S SIGNATURE: **DATE:**

HUMAN RESOURCES' USE ONLY

CBID:	**FT:** ☐ **PT:** ☐ **TEMP:** ☐	**PERMANENT/TENURED:** ☐	
LEAVE CONSULTATION DATE:	**FML ELIGIBILE - YES:** ☐	**NO:** ☐	**FML WEEKS OF ENTITLEMENT:**
FML ESTIMATED EXPIRATION DATE:	**FML USED:**		**LEAVE EFFECTIVE DATE:**
RETURN TO WORK DATE:	**PROBATION *Adjusted* END DATE:**		
TENURE CLOCK STOP DATES:			

HUMAN RESOURCES HAS DETERMINED THAT THIS LEAVE IS QUALIFIED AND MEDICALLY CERTIFIED: YES ☐ **NO** ☐

HUMAN RESOURCES SIGNATURE: _____ **DATE:** _____