LEAVE WITHOUT PAY (LWOP)
REQUEST FORM

Note: A request for LWOP must be approved in advance. All applicable leave time must be exhausted prior to LWOP commencing. Any LWOP absence may affect medical premiums and/or eligibility for health insurance. All LWOP (including Workers Compensation Total Temporary Disability) may affect awarded accrual rates per Employee Handbook section 1.3.1. Employees hired after July 1, 2015, who are on Workers Compensation Total Temporary Disability will earn accruals prorated based on actual hours worked regardless of applicable accrual balances.
Do not use this request for Family Medical Leave absences.

AUTHORIZED _____ **UNAUTHORIZED** _____

EMPLOYEE: _____ **TITLE:** _____
(please print)

DEPARTMENT: _____ **SUPERVISOR NAME:** _____

DATES OF REQUESTED LEAVE

Structured Time Off		Current Sick Accrual Amount _____
1st Day off Date: _____		Current Vacation Accrual Amount _____
End Date: _____		
Return date: _____		Supervisor Initials that are accurate. _____

JUSTIFICATION (To be completed by employee - please provide reasons for request):

SUPERVISOR SECTION
Please provide details on how work will be accomplished is leave is approved:

APPROVAL SECTION

_____ ☐ **Approved** ☐ **Disapproved**
Supervisor *(print name and sign)* **Title**

_____ ☐ **Approved** ☐ **Disapproved**
Department Director *(print name and sign)* **Title**

_____ ☐ **Approved** ☐ **Disapproved**
Human Resource *(print name/sign)* **Title**

Instructions: Forward completed request to Division Director for processing.

cc: Employee, Supervisor, HR

Rev: 07/21/23