



REQUEST FOR LEAVE WITHOUT PAY

Employee Name:	
Department/Division:	
Period of Request: (dates & # of days)	
Reason(s) for request: (e.g., extended illness, academic, maternity, military, etc.):	

In requesting Leave without Pay, I understand the following:

- 1) PTO will not accumulate when both PTO and Banked Sick Leave have been exhausted;
- 2) Continuous service will not be credited for time on Leave without Pay;
- 3) No later than two weeks prior to my scheduled date of return, I will confirm to my responsible Supervisor my date of intended return to active employment. Any request to change my scheduled date of return or intention to resign should be reported as soon as known;
- 4) If returning from a medical leave of absence I shall furnish a signed letter from my personal or "treating" physician, indicating I can resume my employment. Arrangements may be made with the Human Resources Director through my Department Director to be examined by a designated County physician before returning to work;
- 5) I understand that I will be terminated if:
 - a. I fail to furnish a true statement of the reason for leave or required official documentation;
 - b. I accept other employment while on leave, unless a specific request has been applied for and approved in writing;
 - c. I fail to return to work at the expiration of the approved leave.

(NOTE: If a conflict in this policy arises in opposition to any state and/or federal law, the law shall take precedence.)

Signed:

Employee _____ Date _____

Recommended:

Approved / Disapproved (circle one)

Chief Officer / Dept. Director /Date

County Manager /Date

Division Manager/Superintendent /Date

Chief Human Resources Officer /Date