Westfield STATE UNIVERSITY

REQUEST FOR LEAVE OF ABSENCE

Please complete all applicable sections and return it to your supervisor for signature 30 DAYS PRIOR to your anticipated leave, or if your leave is unforeseeable, as soon as possible. Please forward the completed form to Human Resources for processing or email to Benefits@westfield.ma.edu. .

PERSONAL AND CONTACT INFORMATION

Last Name:	First Name:	Payroll ID:
Home Address:		
Best E-mail for leave contact:	Best Phone for leave contact:	
Department:	State Title:	Bargaining Unit:

LEAVE PERIOD

I request that my leave begin on _________________________ and end on _________________________. (If necessary, give approximate dates)

LEAVE REASON

☐	**Employee Illness**	☐	**Medical (non-FMLA)** *(Only available for staff member's own illness/injury)*
☐	**Child/Parent/Spouse Illness**	☐	**Educational or Military**
☐	**Maternity/Paternity**	☐	**Personal**
☐	**Adoption/Placement of Foster Child**	☐	**PFML: Parent of Spouse or Domestic Partner**
☐	**Military Caregiver**	☐	**PFML: Grandparent/Grandchild**
☐	**Military Exigency**	☐	**PFML: Sibling**
☐	**Other (explain)**		

LEAVE TYPE

☐	**Continuous Leave:** *Completely unable to work for consecutive, uninterrupted days.*
☐	**Reduced Leave Schedule:** *A consistent but reduced schedule for multiple weeks.*
☐	**Intermittent Leave:** *Multiple episodes of time off, which may be irregular or unexpected.*

For every leave pattern selected above, estimate details of how leave with be used (use additional sheet, if necessary):

PAY STATUS DURING LEAVE

Identify how time is to be applied

☐	**Sick Leave**	
☐	**Vacation**	
☐	**Personal or Compensatory**	
☐	**PFML**	
☐	**Other**	
☐	**Leave with No Pay**	

EMPLOYEE AUTHORIZATION AND UNDERSTANDING STATEMENTS

- I understand the employer may request a verifying medical certification from an approved medical provider for this leave request. I understand the employer may require a second or third opinion (at the employer's expense) as well as periodic re-certification. I hereby authorize my employer to contact the medical provider to verify the information presented for this leave.
- I understand the employer may require a fitness for duty examination and certification BEFORE my planned return to work date.
- I understand that a failure to return to work at the end of the approved leave period may be treated as a resignation unless a timely extension of leave has been requested by the employee and approved by the employer.
- I understand that if I plan to file for Massachusetts Paid Family and Medical Leave (PFML), I am aware that PFML leave is not considered creditable service for state employees, is not 100% wage replacement, and that there are restrictions on the use of my own accrued leave use with PFML.

SIGNATURES

Employee Signature:	Date:
Supervisor Signature:	Date: