

Request for Leave of Absence Form

Submit completed form to leaves@chapman.edu at least 30 days in advance if the leave is foreseeable, or as soon as possible.

EMPLOYEE INFORMATION			
Employee Name (First, Last, Middle Initial)		Mailing Address	
_____		_____	
Email address While on Leave (non-Chapman University)	City	State	Zip
_____	_____	_____	_____
College/ Department	Telephone Number		
-	_____		
Status (check one):	Last Day worked:		
<input type="checkbox"/> Fulltime <input type="checkbox"/> Adjunct	_____		
Requested start date of leave:	Anticipated return date:		
_____	_____		
REASON(S) FOR LEAVE (ATTACH SUPPORTING DOCUMENTATION, OR PROVIDE WITHIN 30 DAYS OF LEAVE REQUEST)			
Pregnancy (check all that apply) <input type="checkbox"/> Disabled due to pregnancy - Estimated Due Date: _____ <input type="checkbox"/> Request leave to bond with newborn child immediately following pregnancy disability period			
Medical (check all that apply) <input type="checkbox"/> Unable to work due to own serious health condition - Employees Own Serious Health Condition (not work related) <input type="checkbox"/> Intermittent medical leave or a reduced leave schedule, due to own serious health condition			
Family (check all that apply) <input type="checkbox"/> Bonding with newborn child (Estimated Due Date: _____ or Date of Birth _____) <input type="checkbox"/> Adoption, placement, or Foster Care (with employee). Date of placement/adoption: _____ <input type="checkbox"/> Care for spouse, child, parent, or registered domestic partner with a serious health condition. <input type="checkbox"/> Intermittent family leave or a reduced schedule to care for a seriously ill family member.			
Other <input type="checkbox"/> Personal Leave (Non-Medical Reason) <input type="checkbox"/> Military Leave: Active Duty, Military Caregiver or FML <input type="checkbox"/> Other Medical Leave (e.g., leave for extended family members or when employee is ineligible for other leaves) <input type="checkbox"/> Workplace Injury / Worker's Compensation			
ADDITIONAL INFORMATION			
<p>I understand that I am required to file with the State of California for any benefits for which I may be eligible, such as:</p> <ol style="list-style-type: none"> 1. Paid Family Leave (family care, baby bonding, parental leave) 2. State Disability (for absence due to own medical condition) 			
Employee Signature		Date	
_____		_____	

*Please note, requests for leave of absence can take up to five business days to process. Your request will not be approved until you provide the necessary certification. Certification is due **NO LATER THAN 30 DAYS** after your first day missed due to the leave. Your leave request may be denied or partially denied if you do not submit certification within 30 days of your first day missed due to the leave.*