



Villanova University

REQUEST FOR LEAVE OF ABSENCE

(Please submit original to Human Resources)

Name: _____

Dept: _____ Supervisor: _____ Hire Date: _____

Title: _____ Status: F/T P/T Dept. Phone: _____

Home Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____

Leave Requested For:

Self (Medical or Personal) * Care of Others * Military **

* Requires Medical Certification and Statement of Why Leave is Needed ** Requires Copy of Military Order

Leave Requested From: _____ to _____

Unpaid Leaves And Extensions: You will receive no wages while on leave of absence. Vacation, holiday, and paid sick time benefits may be prorated upon return from leave. Please contact the Human Resources office regarding the continuation of your benefits while on leave. *Employees on leave of absence shall not be permitted to accept other employment during such leave. Anyone who violates this policy is subject to termination.*

Return To Work: You must notify Human Resources of your intention to either return to work or to extend your leave at least two (2) weeks prior to the expiration of your approved leave. If you do not report to work on your first scheduled work day following the termination of your leave, you will be considered as having voluntarily resigned. If your health insurance benefits are with Villanova, be sure to contact a Benefits Representative about reinstatement of your insurance benefits under the group plan.

Return From Medical Leave: Before permission to return to work is granted, you must present to Human Resources written certification from your doctor clearing you to return to work.

I understand and agree to the above terms and conditions of my leave of absence.

Employee Signature Date

For Internal Use Only:

| | | | | | |
|----------------------|-----------------------------------|---------------------------------|----------------------|------------------------------|-----------------------------|
| LEAVE REQUEST | <input type="checkbox"/> Approved | <input type="checkbox"/> Denied | HOLD POSITION | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|----------------------|-----------------------------------|---------------------------------|----------------------|------------------------------|-----------------------------|

| | | |
|-------------------------------|---------------|------------------|
| _____ Immediate Supervisor | _____ Date | _____ Phone # |
|-------------------------------|---------------|------------------|

| | | | | | |
|----------------------|-----------------------------------|---------------------------------|----------------------|------------------------------|-----------------------------|
| LEAVE REQUEST | <input type="checkbox"/> Approved | <input type="checkbox"/> Denied | HOLD POSITION | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|----------------------|-----------------------------------|---------------------------------|----------------------|------------------------------|-----------------------------|

| | | |
|-------------------|---------------|------------------|
| * Department Head | _____ Date | _____ Phone # |
|-------------------|---------------|------------------|

| | | | | | |
|----------------------|-----------------------------------|---------------------------------|----------------------|------------------------------|-----------------------------|
| LEAVE REQUEST | <input type="checkbox"/> Approved | <input type="checkbox"/> Denied | HOLD POSITION | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|----------------------|-----------------------------------|---------------------------------|----------------------|------------------------------|-----------------------------|

| | | |
|--------------------------|---------------|------------------|
| _____ Human Resources | _____ Date | _____ Phone # |
|--------------------------|---------------|------------------|

* Department Head – Please indicate by checking one of the above boxes if the position is to be held for the employee on leave of absence.

Turn over for Physician Certification

To Be Completed By Your Physician

Employee Name: _____

Diagnosis: _____

Prognosis: _____

Expected Date of Return: _____

Pregnancy: Normal Expected Date of Delivery: _____
 Complications May Safely Work Until: _____

Restrictions, if any, to the performance of normal job duties: _____

Physician's Signature: _____ Date: _____

Physician's Name (Please Print): _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

For Human Resources Department Use Only:

Vacation Days Available: _____ Sick Days Available: _____

Days To Pay: Sick: _____ Vacation: _____ Date Paid: _____

Last Day Worked: _____ Effective Date Of Leave: _____

Payroll # _____ Bi-weekly 12 Month Salary Grade _____ Salary _____
 Monthly 9 Month

Continuation Of Benefits Yes No

PAF Sent to HR Yes Pay Stopped Yes Not Returned/Terminated Yes
 No No No

Date: _____ Date: _____ Date: _____