

REQUEST FOR UNPAID LEAVE OF ABSENCE FORM

Please complete and return this form to HR as soon as practicable.		
Name:	Coyote ID:	
Address:	City, State, Zip:	
Ph #: ☐ Cell ☐ Home	E-mail:	
Title:	Dept:	Date of Hire:
☐ New Request ☐ Update to previous LOA request, which began on:		
Requested Start Date:	Last date Worked:	
Requested End Date:	Anticipated Return Date:	
☐ Leave will be taken consecutively ☐ Leave will be taken intermittently (Please attached proposed schedule)		
Please indicate the applicable reason(s) for your leave below. If you require additional information about the leave type and their qualifying criteria, please visit the UEC website or call the Benefits Coordinator at UEC-HR at 909-537-7589. *****NOTE: Medical Certification and/or Supporting Documentation will be required within 15 days. *****		
☐ Family Medical Leave (Serious Health Condition): For ☐ Myself ☐ Spouse ☐ Child ☐ Parent ☐ Pregnancy Disability Leave ☐ California Family Rights Act: ☐ Serious Health Condition for myself ☐ Serious Health Condition for Immediate Family Member (Relationship) _____ ☐ Birth/Baby Bonding/Adoption/Foster Care Placement: Expected date of birth/placement: _____ ☐ Reproductive Loss Leave ☐ Military Exigency/Care for Armed Forces Service Member/Reserve Training Leave ☐ Work Incurred Injury or Illness: Date of Injury: _____ ☐ Volunteer Firefighter Leave ☐ Personal Leave/Other: _____		
I certify that my answers given herein are true and complete to the best of my knowledge. I agree that any misrepresentation, false statement, or omission made by me with respect to the information on this request shall be sufficient to disqualify me from consideration. I also understand that my failure to return to work on the specified date will be considered a voluntary resignation effective the next workday, unless I make prior arrangements with UEC HR for an approved extension to my leave.		
Employee's Signature:	Date:	
Supervisor's Signature:	Date:	
HR USE ONLY: ☐ APPROVED ☐ DENIED Signature:	Date:	