Office of Human Resources
Levermore Hall
Room 203 – P.O. Box 701
One South Avenue
Garden City, NY 11530

Application for Leave of Absence

pay and is for a maximum duration of four (4) weeks .

I am requesting consideration of a Personal Leave of Absence from _____ through _______ .
If applicable, I understand that I am responsible for paying the University for my group Health and Welfare benefits to ensure that they will continue through the time of this leave. (Contact the Office of Human Resources for details.)

I understand that I must contact the Office of Human Resources ten (10) working days prior to my expected return date to confirm my return to work.

I understand that I must report directly to the Office of Human Resources for reinstatement. Failure to report on the expected date of return will be viewed as reason to believe that I am not returning to work, and will result in termination of my employment.

By signing below and returning this form to the Office of Human Resources I am confirming my acceptance of the foregoing arrangement.

Print Name | **Employee Signature** | **Date**

Print Name | **Supervisor Signature** | **Date**

For the Office of Human Resources:

Leave of Absence has been:

_______ Approved _________________________________ _____________________
Signature Date

_______ Declined ____________________________