



UNPAID MEDICAL LEAVE

Name _____

Employee # _____

Address _____

Telephone _____

City _____

Zip Code _____

Campus/Dept _____

Position _____

Once your paid leave is exhausted, you will be placed on unpaid leave.

I acknowledge that: (please initial)

_____ I am required to use full pay leave before unpaid leave starts.

_____ I must provide a fitness for duty certificate/medical release prior to being restored to my position if I am out due to a medical condition.

_____ During the months that I do not receive a paycheck, I will be responsible for paying the insurance premiums that would usually be taken from my paycheck.

_____ I must give notice to my campus and to Human Resources at least two weeks prior to returning to work.

_____ **WHEN I RETURN TO WORK, MY CURRENT CONTRACT WILL BE REDUCED BY THE NUMBER OF DAYS I AM OUT ON UNPAID LEAVE AND MY SALARY WILL BE RECONFIGURED BASED ON THE ACTUAL WORK DAYS. THIS WILL AFFECT ALL REMAINING PAYCHECKS DURING THIS CONTRACTURAL YEAR.**

Employee Signature

Date