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**