FORM HR36612

HOUSE OFFICER LEAVE OF ABSENCE REQUEST

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

PART 1: PERSONAL INFORMATION

Last Name:	**First Name:**	**UMID:**	**Institution Start Date:** *(if less than 1 yr, qualifies for Family Care Leave)*
Training Program:		**Date of Request:**	**Projected End Date in MedHub** (Training History tab)**:**

PART 2: LEAVE TYPE

Fill-in the table below for the appropriate leave. Information must also be reflected in MedHub. Refer to the collective bargaining agreement for information regarding leaves of absence.

PART 2a: PAID LEAVE						**For SSC Use Only**
Leave Type	**Leave Start Date:**	**Leave End Date:**	**Total # of Consecutive Days:**	**Will Training be Extended?**	**If yes, Total # of Days:**	**PMOD**
☐ Adoption Leave				☐ Yes* ☐ No		AB
☐ Bereavement Leave**						AT
☐ Jury Duty				☐ Yes* ☐ No		N/A
☐ Maternity Leave				☐ Yes* ☐ No		AB
☐ Secondary Care Provider Leave				☐ Yes* ☐ No		AB
☐ Serious Illness				☐ Yes* ☐ No		AB
PART 2b: UNPAID LEAVE						**PMOD**
☐ Child Care Leave				☐ Yes* ☐ No		AW (FMLA) AA (Non FMLA) HC (Extended Benefits)
☐ Family Care Leave				☐ Yes* ☐ No		AW (FMLA) AT (Non FMLA) HF (Extended Benefits)
☐ Military Leave				☐ Yes* ☐ No		AF
☐ Qualifying Exigency Leave				☐ Yes* ☐ No		AAA
☐ Personal Leave				☐ Yes* ☐ No		AG

** Bereavement is categorized under leave of absence for tracking purposes.

***If Yes, total days above and provide the projected end date of training:**

PART 3: LEAVE INFORMATION

Will vacation be used in conjunction with the LOA?: *For Maternity and Serious Illness Leave, vacation is available on the return to work date (confirmed by Work Connections).*

☐ Yes (complete information below) ☐ No

Vacation Start Date:	**Vacation End Date:**	**Total # of Days:**

For Adoption, Maternity, or Secondary Care Provider Leave, specify Date of Delivery:

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For Bereavement, specify relationship:

Page 2 must be completed and attached

Name (Last, First):	**UMID:**

PART 4: REDUCED EFFORT

Upon return, or to continue training, is reduced effort being implemented? Excludes schedule accommodations listed in the collective bargaining agreement for maternity and secondary care provider leaves.	☐ Yes (complete information below) ☐ No		
	Check One: ☐ Medical Reason *(Work Connections verification required)* ☐ Personal Reason *(Program Director approval required)*		
	% Effort:		
	Start Date:	**End Date:**	**Total # of Consecutive Days:**
	Projected end date of training:		

PART 5: COMMENTS

PART 6: ACKNOWLEDGEMENT AND APPROVAL

Sign below to acknowledge that the information provided is accurate. A House Officer must sign below in any of the following circumstances: training will be extended, unpaid time, and/or reduced effort. If the House Officer is unable to sign, attach the House Officer's email acknowledgement. The Program Director must sign.

House Officer's Name (printed):	**House Officer's Signature:**	**Date:**

Program Director's Name (printed):	**Program Director Approval (signature):**		
	Date:	**Telephone:**	**Uniqname:**

Individual Form Completed By (printed):	**Title of Individual Form Completed By (printed):**		
	Date:	**Telephone:**	**Uniqname:**