

PART 1: PERSONAL INFORMATION

Last Name:	First Name:	UMID:	Institution Start Date: <i>(if less than 1 yr, qualifies for Family Medical Care Leave)</i>
Training Program:		Date of Request:	Projected End Date in MedHub <i>(Training History tab before LOA):</i>

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

Leave Type:	Leave Start Date:	Leave End Date: <i>(last day of leave, NOT return date)</i>	Total # of Consecutive Days:	Will Training be Extended?	If yes, Total # of Days:	PMOD
<input type="checkbox"/> Bereavement Leave**						AB
<input type="checkbox"/> Caregiver Leave				<input type="checkbox"/> Yes* <input type="checkbox"/> No		AB
<input type="checkbox"/> Jury Duty				<input type="checkbox"/> Yes* <input type="checkbox"/> No		N/A
<input type="checkbox"/> Maternity Leave				<input type="checkbox"/> Yes* <input type="checkbox"/> No		AB
<input type="checkbox"/> Parental Leave				<input type="checkbox"/> Yes* <input type="checkbox"/> No		AB
<input type="checkbox"/> Serious Illness				<input type="checkbox"/> Yes* <input type="checkbox"/> No		AB

PART 2b: UNPAID LEAVE

						PMOD
<input type="checkbox"/> Family Medical <u>Care</u> Leave				<input type="checkbox"/> Yes* <input type="checkbox"/> No		AW (FMLA) AT (Non FMLA) HF (Extended Benefits)
<input type="checkbox"/> Military Leave				<input type="checkbox"/> Yes* <input type="checkbox"/> No		AF
<input type="checkbox"/> Qualifying Exigency Leave				<input type="checkbox"/> Yes* <input type="checkbox"/> No		AAA
<input type="checkbox"/> Personal Leave				<input type="checkbox"/> Yes* <input type="checkbox"/> No		AG
<input type="checkbox"/> HOF Transitional Leave (Personal Leave)						HT

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

***If Yes to above, provide the new projected end date of training:**

(current projected End Date in MedHub before LOA + "Total # of Days" from above)

PART 3: LEAVE INFORMATION

Will vacation be used in conjunction with the LOA?: <i>For Serious Illness Leave, vacation is available on the return to work date (confirmed by Work Connections).</i>	<input type="checkbox"/> Yes (complete information below) <input type="checkbox"/> No		
	Vacation Start Date:	Vacation End Date:	Total # of Days:
For Maternity or Parental Leave specify date of delivery or placement:			
For Bereavement, specify relationship:			
Is any, or all, of the House Officer's funding from a grant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> If Yes and a Maternity Leave, a Work Connections Report has been submitted		

Page 2 must be completed and attached

Name (Last, First):	UMID:
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PART 4: REDUCED EFFORT			
<p>Upon return, or to continue training, is reduced effort being implemented?</p> <p>Excludes schedule accommodations listed in the collective bargaining agreement for maternity and parental leaves.</p>	<input type="checkbox"/> Yes (complete information below) <input type="checkbox"/> No		
	Check One: <input type="checkbox"/> Medical Reason (<i>Work Connections verification required</i>) <input type="checkbox"/> Personal Reason (<i>Program Director approval required</i>)		
	% Effort:		
	Start Date:	End Date:	Total # of Consecutive Days:
	Projected end date of training:		

PART 5: ACKNOWLEDGEMENT AND APPROVAL		
<ul style="list-style-type: none"> • 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:

By checking the box, I certify this House Officer LOA request has been reviewed, and agreed upon, with the GME Office

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

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Eligible for FMLA: Yes No