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 Medical Care Leave)*
Training Program:		**Date of Request:**	**Projected End Date in MedHub** (Training History tab **before LOA**):

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: *(last day of leave, NOT return date)*	Total # of Consecutive Days:	Will Training be Extended?	If yes, Total # of Days:	PMOD
☐ Bereavement Leave**						AB
☐ Caregiver Leave				☐Yes* ☐No		AB
☐ Jury Duty				☐Yes* ☐No		N/A
☐ Maternity Leave				☐Yes* ☐No		AB
☐ Parental Leave				☐Yes* ☐No		AB
☐ Serious Illness				☐Yes* ☐No		AB

PART 2b: UNPAID LEAVE

						PMOD
☐ Family Medical 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
☐ 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?:
For 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 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?

☐Yes ☐No

☐If Yes and a Maternity Leave, a Work Connections Report has been submitted

Page 2 must be completed and attached

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

☐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