



PART 1: PERSONAL INFORMATION (LOA) Staff Member to return completed form to supervisor.

Last Name:	First Name:	Middle Name:	UMID:
Department:	Department ID:	Title of Position:	Date of Request:

PART 2: STAFF MEMBER Check the type of leave, supply the required information in writing, and provide attachments as indicated. **Reference Standard Practice Guide 201.30 and 201.30-1, Leaves of Absence.** NOTE: Staff represented by a Union should refer to the collective bargaining agreement that governs the terms and conditions of their employment for information regarding leaves of absence.

PART 2a: LEAVES APPLICABLE TO STAFF

<input type="checkbox"/>	Child Care	State the date of the child’s birth, adoption, or foster placement. Date: _____
<input type="checkbox"/>	Educational	Indicate school and credit hours. If not a UM student, attach a completed Educational Leave of Absence Addendum, available at http://www.hr.umich.edu/hrris/forms/pdfs/edleavead2.pdf , to verify registration.
<input type="checkbox"/>	Family Care	Attach U.S. Department of Labor Certification of Health Care Provider for Family Member’s Serious Health Condition (Family and Medical Leave Act), Form WH-380-F (http://www.dol.gov/whd/forms/).
<input type="checkbox"/>	Government Service	Indicate the nature and duration of the government service.
<input type="checkbox"/>	Intergovernmental Personnel Assignment	Attach OF69 Assignment Agreement. (Refer to SPG 201.30-5, Federal Personnel Agreements.)
<input type="checkbox"/>	Military Service	Attach a copy of the Notice of Induction or Authorization for Active Duty.
<input type="checkbox"/>	Qualifying Exigency	Attach U.S. Department of Labor Certification of Qualifying Exigency For Military Family Leave (Family and Medical Leave Act), Form WH-384 (http://www.dol.gov/whd/forms/).
<input type="checkbox"/>	Care of a Covered Servicemember	Attach U.S. Department of Labor Certification for Serious Injury or Illness of Covered Servicemember - for Military Family Leave (Family and Medical Leave Act), Form WH-385 (http://www.dol.gov/whd/forms/).
<input type="checkbox"/>	Personal Medical	If receiving Workers’ Compensation, indicate whether you want to exhaust your vacation time before the leave begins.
<input type="checkbox"/>	Personal	State the reason for requesting the leave: _____ <i>Note: System lists end of leave with return to work.</i>
<input type="checkbox"/>	Seasonal Leave	Use this form to establish the initial seasonal leave period. (Refer to SPG 201.30-3, Seasonal Leave of Absence Appointment.) <i>Note: System lists end of leave with return to work.</i>

PART 2b: LEAVE ACKNOWLEDGEMENT

Returning to work before the leave expiration date is at the discretion of the University. Benefit plans not continued during the leave (self and dependents, if applicable) will be reinstated upon return from leave into a benefit eligible appointment. Deductions for reinstated benefits will resume.

Office Phone:	Staff Signature:	Home Phone:	Home Address:
---------------	------------------	-------------	---------------

MICHIGAN MEDICINE STAFF LEAVE OF ABSENCE AND LAYOFF WORKSHEET

Name (Last, First, Middle):

UMID:

PART 3: LEAVE INFORMATION: SUPERVISOR/DEPARTMENT ADMINISTRATOR/HR -
Please indicate leave type and length of leave. Complete all required information (if applicable) in writing and provide attachments as indicated.

FOR HSHR USE ONLY

Date Paid _____ (Note: Verify last day of pay with timekeeper or
Time Ends: _____ payroll representative for staff members only.)

Pmod:

Leave Begin Date: _____ Leave End Date: _____

Leave Type:

Is a portion of this leave covered under FMLA? Yes No
If yes, list dates covered under FMLA below in Part 4: Leave Comments.

FMLA PMOD:

PART 4: LEAVE COMMENTS *Please attach a copy of the FMLA notification letter required for processing.*

PART 5: AUTHORIZATION

Contact/Preparer Name:	Contact/Preparer Signature:	Date Signed:	Phone:
Supervisor's/Department Chair's Name	Supervisor's/Department Chair's Signature:	Date Signed:	Phone:
EPC/HR Generalist Name:	EPC/HR Generalist Signature:	Date Signed:	Phone:

PART 6: REQUEST FOR LAYOFF STATUS FROM ALL REGULAR APPOINTMENTS

Reference Standard Practice Guide 201.72, Reduction in Force. *Attach letter to staff member and other approvals as appropriate.

Last Name:	First Name:	Middle Name:	UMID:
Department:	Department ID:	Title of Position:	Date of Request:
Effective Date (day after last day employed, mm/dd/yyyy):	Last Day Employed (mm/dd/yyyy):	RIF End Date (mm/dd/yyyy):	
<input type="checkbox"/> Lack of Funds (Code: LA)	<input type="checkbox"/> Change in Workload (Code: LB)	<input type="checkbox"/> Completion of Project (Code: LD)	<input type="checkbox"/> Reorganization, Eliminating Position (Code: LE)

PART 6a: LAYOFF STATUS COMMENTS

			Was employee notified? <input type="checkbox"/> Yes <input type="checkbox"/> No
FOR EPC/HR GENERALIST USE ONLY: LG PMOD <input type="checkbox"/> P Flag <input type="checkbox"/> Initial/Date: _____ / _____			

Approved by Department Head:		Dean/Director or Representative:		HR Representative/Consultant:	
Telephone:	Date:	Telephone:	Date:	Telephone:	Date:

**INSTRUCTIONS FOR STAFF LEAVE OF ABSENCE AND LAYOFF WORKSHEET****This form is used for:**

- Staff unpaid leave of absence (Part 2a).
- Employee Reduction in Force (RIF) status. **Complete Parts 5 and 5a (the sections highlighted in blue) on page 2, only.**

This form needs to be prepared when:

- Staff member requests a leave of absence or has an unexpected, long-term absence.
- Determination that reduction in the working force is necessary and the affected staff member has been identified.

PLEASE INCLUDE THE FOLLOWING INFORMATION:**PART 1: PERSONAL INFORMATION (Leave of Absence)**

- Employee name.
- UMID.
- Department information.
- Date of request.

PART 2: STAFF MEMBER (Reference Standard Practice Guide 201.30 and 201.30-1, Leaves of Absence)

- Completed by staff member.
- Complete Part 2a.
- Staff signature, office phone, home address and home phone.

PART 2a: LEAVES APPLICABLE TO STAFF

- Section can be used for staff unpaid leaves.
- Determine the type of unpaid leave for this employee.
- Provide required attachments (if any) for the type of leave you have chosen.

PART 2b: LEAVE ACKNOWLEDGEMENT

- Completion of Staff Signature and contact information.

PART 3: LEAVE INFORMATION

- Completed by staff member's supervisor/department administrator.
- Provide date paid time ends (day before unpaid leave begins).
- Provide leave begin and end dates.
- FMLA leave designation
- Personal and Seasonal leaves are processed with a return to work date. All other leaves require a Job PAR submittal form to return to work.

INSTRUCTIONS FOR STAFF LEAVE OF ABSENCE AND LAYOFF WORKSHEET *(continued)***PART 4: LEAVE COMMENTS**

- Provide any Leave of Absence comments with paid or unpaid time periods.
- Provide any FMLA comments.
- FMLA notification letter is required.

PART 5: AUTHORIZATION

- Preparer/Contact information: name, signature, date and phone number.
- Supervisor/Department Chair information: name, signature, date and phone number.
- EPC information: name, signature, date and phone number.

PART 6: REQUEST FOR LAYOFF STATUS FROM ALL REGULAR APPOINTMENTS

(Reference Standard Practice Guide 201.72, Reduction in Force)

If the request is for a layoff, enter the effective date (the day after the last day employed, in most cases).

- The end date is determined by the length of service of the employee being affected by the RIF (reduction in force).
 - Non-union employees with at least one year of service will be on RIF status for one year. The end date would be one year minus one day from the begin date of the RIF, and the last day employed is the RIF end date.
 - Example: If the date of hire is 10/13/96 and the effective date of the RIF is 4/13/98, the employee has been employed for more than one year so the end date of the RIF will be 4/12/99.
 - Example: If the date of hire is 10/13/96 and the effective date of the RIF is 7/13/97, the employee has been employed nine months so the end date of the RIF will be 4/12/98.
 - Nursing employees with at least eighteen months of service will have a RIF period of eighteen months. If the length of service is less than eighteen months, the length of the RIF will equal the length of service.
 - AFSCME employees' RIF status is equal to the length of service if the period is two years or less.
- Check the appropriate box to indicate the reason for the layoff.

PART 6a: LAYOFF STATUS COMMENTS

- Enter any remarks about the reason for layoff or other comments for HR.
- Indicate employee notification status.
- Obtain Department Head and Dean/Director or Representative signatures, dates signed and phone numbers and forward to your HR Representative/ Consultant for their review and processing.