ROGER WILLIAMS UNIVERSITY AND ROGER WILLIAMS UNIVERSITY SCHOOL OF LAW
REQUEST FOR A NON-FMLA LEAVE OF ABSENCE

INSTRUCTIONS: Please complete the form, read the statement on page 2, sign and date it and return to the Department of Human Resources to the attention of the Benefits Specialist. **If the leave request is due to medical reasons, please include a signed note from the treating physician with the following information: Date first unable to work, length of time expected to be unable to work and expected return to work date.**

Employee Name _____ ***Last 4 digits of Social Security #:*** _____

Address _____ ***City & State*** _____ ***Zip Code*** _____

Position _____ ***Department*** _____

Supervisor's Name _____

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1. My requested leave will begin on ____/____/____ and end on ____/____/____

2. Type of Non-FMLA leave requested.

- ☐ **Extraordinary Leave of Absence**
  (Available to Non-Aligned, School of Law, Dining Union, Facilities Union, PSO Union and PSSA Union Employees)
- ☐ **Sick Leave of Absence**
  (Available to PSSA Union Employees)
- ☐ **Personal Leave of Absence**
  (Available to Dining Union Employees and School of Law Faculty)
- ☐ **Parental Leave of Absence**
  (Available to Faculty Union and School of Law Faculty)
- ☐ **Academic Leave of Absence**
  (Available to Faculty Union Employees)
- ☐ **Professional Leave of Absence**
  (Available to School of Law Faculty)

3. Describe the reason for this leave request.

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4. Benefit Continuation Election (if applicable):

A. GROUP MEDICAL BENEFIT
- ☐ I elect to continue my medical coverage
- ☐ I elect to cancel my medical coverage

B. GROUP DENTAL BENEFIT
- ☐ I elect to continue my dental coverage
- ☐ I elect to cancel my dental coverage

I understand that I am responsible for the entire medical and/or dental premiums for coverage continued during any of the above leaves of absence if I am in an **unpaid status**. ***This does not apply to an Academic Leave or Professional Leave of Absence.***

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5. Conditions:

1. I will not accept other employment during the period of this leave.
2. If I do not return to work after this leave period expires my employment may be terminated, and I may be liable for the full benefit premiums paid on my behalf by the University.
3. When this leave ends I understand I may or may not be returned to my position or a similar one.
4. I understand that if my leave is for medical reasons I must submit a doctor's note releasing me to full duty.
5. If you are on an Extended or Sick Leave of Absence, all accrued sick and vacation leave will be utilized during the course of this leave with accrued sick time used first.
6. Approval of these leaves is at the sole discretion of the University. Approval or denial of the requested leave shall be provided by the University along with any terms of the approved leave.

Signature and Acknowledgment:

I certify as to the truth and accuracy of the information I provided on this form.
I further understand that if leave is due to a health condition, I must submit periodic, updated medical information completed by the appropriate health care provider at the University's request.

_____ ____/____/____

Employee Signature ***Date***

6. Human Resources Review

_____ _____/_____/_____

Authorized University Signature **Date**

Approved ☐ **Denied** ☐

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