Area Agency on Aging of Western Arkansas
and Visiting Nurses Agency
"Our heart is in your home."

LEAVE OF ABSENCE WITHOUT PAY REQUEST FORM ***

Name: ___________________________________ Date: _______________

Status (check one): ( ) Full-Time ( ) Part-Time

Location: ____

Department: ____

I, __________________________, request an unpaid leave of absence to begin ___________ and to end ____________ for the following reason: (check one)

( ) Personal Medical ( ) Personal Non-Medical

( ) Military ( ) Other _______________________

I have received a copy of the Leave of Absence Without Pay Policy.

____ __________________

Employee Signature Date

Extension Request:

I, __________________________, am currently on a (check one)

( )Personal Medical ( )Personal Non-Medical

( )Military ( )Other_______________________

unpaid leave of absence which began on _____________. I would like to request an extension to be continued from ______________ and to end on ______________.

____ _________________

Employee Signature Date

***Please do not use this form if you believe you may be entitled to leave under the Family and Medical Leave Act and/or Military Family Leave or for an employee requesting leave for his or her own military service. Leave should be requested under the Family Medical Leave Act first and different provisions apply for your own military service. Please contact Human Resources if you have any questions.

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LEAVE OF ABSENCE WITHOUT PAY
REQUEST FORM

Approval:

Leave approved: ________

Leave denied: ________

________________________________ ____________________
Supervisor Date

Leave approved: ________

Leave denied: ________

________________________________ ____________________
Human Resources Manager Date

Leave of Absence Condition: (To be completed by Payroll)

Check Insurance to be continued and the weekly/monthly cost to employee.

Medical	( ) Yes	( ) No	( ) N/A	$__________
Dental	( ) Yes	( ) No	( ) N/A	$__________
Other	( ) Yes	( ) No	( ) N/A	$__________

Total insurance premium due per week $__________

Total insurance or premium due per month $__________