FSCJ Florida State College at Jacksonville

Full-time Employee Leave Without Pay (LWOP) Request

The **Employee** is to inform supervisor and complete LWOP Request no less than 30 days prior to "Leave to start" date. When LWOP is unforeseeable, the employee must apply within a reasonable period of time, appropriate to the circumstances involved. **NOTE:** Employee must attach supporting documentation, e.g., doctor's certification, military orders, etc.

An employee who is taking LWOP must exhaust all sick, non-compensatory sick, and annual leave prior to being eligible for unpaid leave. This also includes comp time tracked in the payroll timesheet.

A **Supervising Administrator** may grant LWOP for up to ten consecutive work days and the **Vice President**, or designee, may approve LWOP for a maximum of six months. The **Supervising Administrator** submits the approved LWOP Request and attachments to the Benefits Office. There is no automatic renewal of the LWOP Request, and the employee must apply for an extension to the current LWOP Request 30 days prior to the expiration of the Request.

The **Employee** must decide whether or not to continue benefits coverage for self and/or dependent(s) at full cost and inform the Benefits Office prior to going on LWOP. If the employee voluntarily declines benefits during LWOP, reinstatement of benefits will be effective the first day of the following month after the employee returns to work. Employees will be financially responsible for claims if premiums are not paid and coverage is cancelled. **NOTE:** Non-pay Status affects various employee entitlements, including the accrual of annual and/or sick leave.

The **Benefits Office** will verify the LWOP Request to ensure Non-pay Status is appropriately recorded prior to payroll processing.

Please refer to APM 03-1012 and APM 03-1005 for additional guidelines.

For questions, please contact benefits@fscj.edu.

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Leave without Pay Request Form

Date:_____ EMPLID: _____

Employee Name:_____Title/Position: _____

Home Address:_____Home Phone: _____

_____

Department:_____Reports to: _____

Hire Date:_____Length of Service:_____Leave taken in past 12 months? _____

Leave to start:_____ Expected return date: _____

Leave is being requested for the following reason:

_____

_____

_____

_____

If leave is being requested for a serious health condition of the employee, a physician's statement indicating the need for leave must be attached. A Return to Work notice indicating no restrictions will also be required prior to the employee's return to work.

Employee Signature_____ Date: _____

Supervising Administrator Signature_____ Date: _____
(Can approve up to ten (10) consecutive work days)

Vice President Signature_____ Date: _____
(Can approve up to six (6) months)

Benefits Office Signature_____ Date: _____