Rowan University

# SICK LEAVE OF ABSENCE REQUEST FORM

Name: _____ Rowan ID: _____ Ext: _____
Last First MI

Date of Hire: _____ Email: _____ Home phone:_____

Department: _____ Supervisor: _____

I am requesting leave for the following time period:

Leave Begin Date: _____ Leave End Date: _____

Phone number where you can be reached while on leave: _____

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I am requesting a Sick Leave of Absence: ***Please indicate how you wish to use time balances***
_____ with pay using: Only earned _____ sick _____ vacation _____ AL _____ comp. time **OR**
_____ with pay using: All earned/unearned* _____ sick _____ vacation _____ AL _____ comp. time
_____ without pay

I understand medical documentation supporting this leave request is required to be submitted. If this leave is without pay, I understand I am responsible for paying the premium for health and dental coverage for up to three months. If the unpaid leave is extended beyond three months, I am responsible for the full cost of health and dental benefits while on leave without pay.
* Leave time does not accrue during a leave of absence without pay. For every month without pay, leave