

Application for Leave of Absence Without Pay

To:	Manager:				
From:	Employee Name:				
	Position Title:Phone/Email:				
	I hereb	y apply for a leave of absence f	rom the Universit	y of Arkansas System Division of Agricu	Iture as follows:
Beginning Date:		End	Ending Date:		
			requested. If the absence is necessary l ase contact Human Resources before su		
If leave	is granted to me, I understand	the following:			
	my accumulated annual leave naternity leave or certain types of		prior to taking leave without pay, excep	t if this leave qualifies as	
• Iw	vill not earn sick leave or annual	leave if I am on lea	ave without pay for 10 or more days dur	ing a calendar month;	
• Iw	vill not be paid for University Ho	lidays while on lea	ve without pay;		
			period of leave without pay is insufficier	· · · · · · · · · · · · · · · · · · ·	
		ns, I may continue	to participate by paying the total cost (r	ny part and the Division's	
-	rt) of the premiums;				
	rail to report to work promptly vision may be terminated;	at the end of an ag	greed-upon period of leave without pay,	my employment with the	
For mo	re information, please see Board	d of Trustees Polici	es 420.6 or Division policy PMGS 21-01.		
Employ	vee Signature:		Date:		
Approv					
Dent H	lead Signature:		Date:		
Sept. 1			butc.		
 Chief H	uman Resources Officer	Date	Sr. Associate Vice President	Date	
Vice Pr	esident for Agriculture	 Date	 President	 Date	

^{*}Route for signatures using software such as DocuSign, Box, etc in the following order: Chief HRO, Sr AVP, VP, and President

^{**}Send a completed copy of form to your benefits@uada.edu and payroll@uada.edu for processing. 08/16/2022