LEAVE OF ABSENCE STATUS CHANGE FORM D

SUBMIT IN THE PAY PERIOD IN WHICH THE EVENT OCCURS
FAX TO 480.993.0007

Employee Name______________________________ Date:______________

Employee 10-digit ID Number: ______________________________

Department Name: ______________________________ Department Number: __________

CHANGE LEAVE DATE

Revised Leave Begin Date: ______________________________

Revised Return to Work Date: ______________________________

CHANGE LEAVE TYPE EFFECTIVE DATE:______________________

From:
- ☐ FMLA
- ☐ FMLA: Workers' Compensation
- ☐ Extended Leave (Staff)
- ☐ Extended Leave (Staff): Workers' Compensation
- ☐ Health Related Leave (Faculty/sick)
- ☐ Leave Without Pay (Faculty)
- ☐ Leave Without Pay(Faculty): Workers' Compensation
- ☐ Parental
- ☐ Military

To :
- ☐ FMLA
- ☐ FMLA: Workers' Compensation
- ☐ FMLA Exhausted
- ☐ FMLA Exhausted: Workers' Compensation
- ☐ Parental
- ☐ Termination: Reason ______________

CHANGE PAY STATUS EFFECTIVE DATE:______________________

From:
- ☐ Paid
- ☐ Unpaid

To:
- ☐ Unpaid
- ☐ Paid

CHANGE LEAVE SCHEDULE EFFECTIVE DATE:______________________

From:
- ☐ Continuous
- ☐ Intermittent

To:
- ☐ Intermittent
- ☐ Continuous

RETURN TO WORK EFFECTIVE DATE ______________________

FROM MEDICAL LEAVE: **ATTACH COPY OF HEALTH CARE PROVIDER RELEASE TO RETURN TO WORK**

FROM MILITARY LEAVE: **ATTACH COPY OF (1) DUTY ORDERS AND (2) DISCHARGE FROM ACTIVE DUTY**

COMMENTS:____

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______________________	______________________	______________
Supervisor/Designee Name	*Supervisor/ Designee Signature*	*Date*
______________________	______________________	______________
Budgetary Approval: VP/Dean/Designee Name	*VP/Dean/Designee Signature*	*Date*