



Office of Human Resources
 Levermore Hall
 Room 203 – P.O. Box 701
 One South Avenue
 Garden City, NY 11530

Application for Leave of Absence

payands for a maximum duration offour(4)weeks .

Iam requesting consideration of a Personal Leave of Absence from _ _ _ _ through _ _ _ _ .
 f applicable, I understand that I am responsible for paying the diversity for my group Health and
 Welfare benefits to ensure that they will continue through the time of this leave. (Contact the Office of
 Human Resources for details)

I understand that I must contact the Office of Human Resources ten (10) working days prior to my
 expected return date to confirm my return to work

I understand that I must report directly to the Office of Human Resources for reinstatement. Failure to
 report on the expected date of return will be viewed as cause to believe that I am not returning to
 work and will result in termination of my employment.

By signing below and returning this form to the Office of Human Resources I am confirming my
 acceptance of the foregoing arrangement.

Print Name Employee Signature Date

Print Name Supervisor Signature Date

For the Office of Human Resources:

Leave of Absence has been:

_____ Approved _____
 Signature Date

_____ Declined _____