UNIVERSITY OF VIRGINIA HEALTH SYSTEM, MEDICAL CENTER
REQUEST FOR PERSONAL/EDUCATIONAL LEAVE

Name: _____ID#: _____
Home Phone: _____ Status: ☐ Full-time, ☐ Part-time, ☐ Wage
Department: _____ Position: _____ Work Phone: _____

I request ☐ Personal or ☐ Educational Leave beginning _____ and expected to end _____. This request is to care for a family member with a serious illness ☐ Yes or ☐ No.
I understand and agree to the following provisions:

1. Personal/Educational leave may be granted for up to twelve (12) consecutive months. I will be required to first use any accrued paid leave time before taking unpaid leave.

2. Subject to the terms, conditions, and limitations of the applicable plans, the Medical Center will continue to provide life, health, and disability insurance benefits for the full period of the personal/educational leave***. For a Personal Leave of absence, during any period of leave without pay, I will be responsible for paying the entire cost of these benefit plans, which includes both the employer and employee contributions. For an Educational Leave, I will be responsible for the employee portion of the contributions.***

3. Paid time off accrual is suspended after 4 consecutive pay periods of paid leave. Paid time off accrual is also suspended during any period of leave of absence without pay. Paid time off accrual resumes upon return to active employment.

4. When my leave ends, reasonable effort will be made to return me to the same position, if it is available, or to a comparable vacant position for which I am qualified. However, the Medical Center does not guarantee me reinstatement.

Employee's Signature: _____ Date: _____

To be completed by supervisor:

Personal Leave is ☐ approved, ☐ disapproved for the period beginning _____ and ending _____.

_____ _____ _____
Supervisor's Name Supervisor's Signature Date

_____ _____
Address/Box # Phone #

Submit copy to UVA HR Solution Center, leave@virginia.edu or via fax at 434-924-4042.