DATE

NAME

ADDRESS

CITY/STATE/ZIP

DEAR (DEPARTMENT CHAIR /SUPERVISOR NAME)

I am hereby requesting permission to take an unpaid leave of absence for LIST SEMESTERS IF NINE-MONTH FACULTY OR BEGINNING AND END DATES IF 12-MONTH FACULTY. I understand that an unpaid leave of absence may not be granted for a period of more than 12-months.

The professional or personal reasons why I wish to take this leave are as follows:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requestor’s Signature Requestor’s Printed Name

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| I recommend the granting of this request for an unpaid leave of absence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DEPARTMENT CHAIR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date | I concur with the granting of this request for an unpaid leave of absence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DEAN, SCHOOL OF MEDICINE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |
| Request for unpaid leave of absence granted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Keith E. Whitfield, Provost Date |
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