# HOUSE OFFICER LEAVE OF ABSENCE REQUEST

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN



## PART 1: PERSONAL INFORMATION

| Last Name: | First Name: | UMID: | Institution Start Date: *(if less than 1 yr, qualifies for Family Medical Care Leave)* |
|---|---|---|---|
| Training Program: | | Date of Request: | Projected End Date in MedHub (Training History tab **before LOA**): |

## PART 2: LEAVE TYPE

Fill-in the table below for the appropriate leave. Information must also be reflected in MedHub. Refer to the collective bargaining agreement for information regarding leaves of absence.

### PART 2a: PAID LEAVE

| Leave Type: | Leave Start Date: | Leave End Date: *(last day of leave, NOT return date)* | Total # of Consecutive Days: | Will Training be Extended? | If yes, Total # of Days: | PMOD |
|---|---|---|---|---|---|---|
| ☐ Bereavement Leave** | | | | | | AB |
| ☐ Caregiver Leave | | | | ☐ Yes* ☐ No | | AB |
| ☐ Jury Duty | | | | ☐ Yes* ☐ No | | N/A |
| ☐ Maternity Leave | | | | ☐ Yes* ☐ No | | AB |
| ☐ Parental Leave | | | | ☐ Yes* ☐ No | | AB |
| ☐ Serious Illness | | | | ☐ Yes* ☐ No | | AB |

### PART 2b: UNPAID LEAVE

| | | | | | | PMOD |
|---|---|---|---|---|---|---|
| ☐ Family Medical Care Leave | | | | ☐ Yes* ☐ No | | AW (FMLA)<br>AT (Non FMLA)<br>HF (Extended Benefits) |
| ☐ Military Leave | | | | ☐ Yes* ☐ No | | AF |
| ☐ Qualifying Exigency Leave | | | | ☐ Yes* ☐ No | | AAA |
| ☐ Personal Leave | | | | ☐ Yes* ☐ No | | AG |
| ☐ HOF Transitional Leave (Personal Leave) | | | | | | HT |

** Bereavement is categorized under leave of absence for tracking purposes.

***If Yes to above, provide the new projected end date of training:**

(current projected End Date in MedHub before LOA + "Total # of Days" from above)

## PART 3: LEAVE INFORMATION

**Will vacation be used in conjunction with the LOA?:** ☐ Yes (complete information below) ☐ No

*For Serious Illness Leave, vacation is available on the return to work date (confirmed by Work Connections).*

| Vacation Start Date: | Vacation End Date: | Total # of Days: |
|---|---|---|
| | | |

**For Maternity or Parental Leave specify date of delivery or placement:**

**For Bereavement, specify relationship:**

**Is any, or all, of the House Officer's funding from a grant?** ☐ Yes ☐ No

☐ If Yes and a Maternity Leave, a Work Connections Report has been submitted

**Page 2 must be completed and attached**

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| **Name (Last, First):** | **UMID:** |
|---|---|
| , | |

## PART 4: REDUCED EFFORT

| | | | |
|---|---|---|---|
| **Upon return, or to continue training, is reduced effort being implemented?**<br><br>Excludes schedule accommodations listed in the collective bargaining agreement for maternity and parental leaves. | ☐ Yes (complete information below) ☐ No | | |
| | **Check One:**<br>☐ Medical Reason *(Work Connections verification required)*<br>☐ Personal Reason *(Program Director approval required)* | | |
| | **% Effort:** | | |
| | **Start Date:** | **End Date:** | **Total # of Consecutive Days:** |
| | **Projected end date of training:** | | |

## PART 5: ACKNOWLEDGEMENT AND APPROVAL

- Sign below to acknowledge that the information provided is accurate.
- A House Officer must sign below in any of the following circumstances: training will be extended, unpaid time, and/or reduced effort. If the House Officer is unable to sign, attach the House Officer's email acknowledgement.
- The Program Director must sign.

| **House Officer's Name (printed):** | **House Officer's Signature:** | **Date:** |
|---|---|---|
| | | |

| **Program Director's Name (printed):** | **Program Director Approval (signature):** | | |
|---|---|---|---|
| | **Date:** | **Telephone:** | **Uniqname:** |
| | | | |

☐ By checking the box, I certify this House Officer LOA request has been reviewed, and agreed upon, with the GME Office

| **Individual Form Completed By (printed):** | **Title of Individual Form Completed By (printed):** | | |
|---|---|---|---|
| | **Date:** | **Telephone:** | **Uniqname:** |
| | | | |

**HR Solutions Center Use Only**

Eligible for FMLA: ☐ Yes ☐ No