



Department of Transformation and Shared Services
Office of Personnel Management
Request for Leave Without Pay

Section A: *(To be completed by Employee)*

Name _____ Personnel Number _____
Office _____ Position Number _____
LWOP Beginning Date _____ LWOP Ending Date _____

Reason for Request:

Signature _____ Date _____

Note: During periods of LWOP it is the responsibility of the employee to pay the total cost of his/her State Employees Group Health and Life Insurance, to include the State's matching portion. When approved for LWOP, a payment schedule will be provided. Failure to comply with the due dates and premium amounts reflected on that schedule will mean immediate cancellation of the Group Health and Life Insurance.

Section B: *(To be completed by the Supervisor)*

Name _____ Title _____
Approval: Yes No
Signature _____ Date _____

Section C: *(To be completed by the HR Administrator)*

Name _____ Title _____
Approval: Yes No Signature _____
Date _____

Section D: *(To be completed by the Department Secretary or designee)*

Name _____ Title _____
Approval: Yes No
Signature _____ Date _____