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 _____