Print Form

USP-21

Maternity Leave Form
Accrued Hours Discharge Request

I, _____ am requesting the following time be discharged prior to the effective date of my leave without pay.
(Employee Name)

Vacation		# of Days
Personal		# of Days
Comp Time		# of Days
SRP 0r Deferred Vacation		# of Days
*Sick		# of Days

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*Sick leave may be discharged only when appropriate medical documentation is provided.

Please designate either the projected end date or the amount of time you are requesting for your leave without pay.

NOTE: Health Benefits will continue.

Anticipated LWOP to begin _____

End Date of Leave Requested _____

_____ _____
Date Employee's Signature

_____ _____
Date Supervisor's Signature

Your first **LWOP** day will begin when the hours listed above are completely discharged. This first day of **LWOP** will then be the actual effective date of your maternity leave and the Employee Action Form leave request date.

Please contact **Mary Previte** at **874-2684** in the Office of Human Resource Administration if you have any questions.