Berklee College of Music

REQUEST for LEAVE OF ABSENCE

Return Completed Form to the Benefits Department
njordan@berklee.edu

INSTRUCTIONS: If you can anticipate the need for your time away from work, submit this form at least 30 days before your absence begins (60 days for faculty Parental Leave *per* the Faculty Contract Agreement). Otherwise, submit as soon as possible**.**

DOCUMENTATION REQUIREMENTS: You will be required to provide additional documentation to support your request for Leave of Absence. Based upon the reason for your leave, the appropriate additional forms will be sent to you by email.

APPROVAL PROCESS: Your request for Leave of Absence is subject to approval. You will receive confirmation of the approved dates.

Your Legal Name: _____ **Berklee ID Number:**_____
(see your Berklee ID card)

Work Phone:_____**Home/Cell Phone:** _____ **Preferred Email (during leave):** _____
so we can contact you

Status: ☐ **Faculty; full-time** ☐ **Faculty; part-time** ☐ **Staff; full-time** ☐ **Staff; part-time** ☐ **Other**

SUPERVISOR/CHAIR:_____ **DEPARTMENT**: _____

TYPE of LEAVE of ABSENCE (choose one)

☐ MATERNITY (delivering mother) ☐ PARENTAL (non-delivering parent) ☐ ADOPTION/FOSTER CARE

☐ YOUR MEDICAL CARE ☐ FAMILY MEMBER MEDICAL CARE ☐ YOUR MILITARY SERVICE

☐ DUE to MILITARY SERVICE of FAMILY MEMBER (active or veteran) ☐ FACULTY PROFESSIONAL/SPECIAL LEAVE

☐ FACULTY EXTENDED UNPAID PARENTAL ☐ OTHER; describe: _____

HOW YOU PROPOSE to TAKE YOUR LEAVE (choose one)

☐ **All at once** ☐ **Intermittently** ☐ **Reduced work schedule**

WHEN YOU PROPOSE to TAKE YOUR LEAVE – Subject to approval. You will receive confirmation of approved dates.

LEAVE BEGINS (1st day away from work): _____ ☐ anticipated or ☐ actual

DATE of RETURN to WORK: _____ ☐ anticipated or ☐ actual

For STAFF, only (not FACULTY)

Use of PTO during 1st 5 days of Maternity Leave (delivering mother, only) **or Medical Care Leave**

☐ *Pay me using my PTO for the 1st 5 days of my leave. HR will register this PTO usage for me.*

☐ *Do not pay me for the 1st 5 days of my leave.*

YOUR SIGNATURE

You understand that your request for leave of absence is subject to approval. If your request is approved, you accept the following conditions: (1) Upon expiration of medical care leave, for your medical care, you agree to furnish the Benefits Department with a physician's statement indicating that you are medically able to return to work. (2) If you fail to return to work on the approved date, your employment may be subject to termination. (3) If you participate in the college's benefits plans, it is your responsibility to make arrangements—if necessary—with the Benefits Department or its agent to continue the appropriate contributions and/or premium payments while on leave, to the extent permitted by law. (4) If you are a faculty member, subject to the *Faculty Contract Agreement*, you understand that any pay continuation during an approved leave of absence will be in accordance with the *Faculty Contract Agreement*.

FACULTY/STAFF MEMBER: _____ DATE: _____

SUPERVISOR/CHAIR:_____ DATE: _____