



Albert Einstein College of Medicine

1199 Unpaid Leave of Absence Request Form

Pursuant to Article XVIII of the collective bargaining agreement between Albert Einstein College of Medicine ("Einstein") and 1199 SEIU, bargaining unit members may be eligible for *unpaid* leaves of absence without loss of seniority or status. Bargaining unit members seeking a leave of absence should refer to Article XVIII the collective bargaining agreement for specific guidelines, eligibility requirements and return to work conditions. Absent extenuating circumstances, Sections I – III of the Unpaid Leave of Absence Request Form must be fully completed and submitted to Einstein's Benefits Office at least sixty (60) days prior to the requested leave commencement date. If you have questions about your leave or if circumstances change during your leave, contact Einstein's Benefits Office immediately at (718) 430-2566 or by email at benefits@einsteinmed.edu.

Section I: Employee Information

Employee Name: _____ Department: _____

Address during Leave: _____

Phone during Leave: _____ Cell Phone: _____

Email during leave: _____

Section II: Reason for Leave Request (check one):

- ☐ Education (up to 12 months) ☐ Medical* (up to 2 years) ☐ Maternity* (up to 12 months) ☐ Union (up to 2 years)
☐ Personal (up to 12 months) ☐ Military (as required by law) ☐ To care for an immediate family member who is seriously ill (9 weeks)

First Day of Leave: _____

Return to Work Date: _____

**You may only apply for a medical or maternity leave if you have exhausted (or are ineligible) for federal or state mandated leaves (FMLA and or New York State Paid Family Leave). All applicable leaves run concurrently.*

If you are requesting a medical leave, some or all of your time may be covered by accrued sick pay, accrued vacation pay (if requested) and Disability benefits through the Union. If your request for a medical is for your own serious health condition you must present a return to work note stating full duty or no restrictions apply. If restrictions apply, they must be specific and clearly listed and will be reviewed for accommodation.

Section III: Employee Acknowledgement

I agree to conform to the terms and conditions of the 1199 Collective Bargaining Agreement and Einstein's Leave of Absence Policy and acknowledge that:

- If approved, my leave of absence may be without pay, including pay for holidays that fall during the leave,
- If approved, I may not accrue additional sick, vacation or personal time while on a leave of absence,
- Any requested change to an approved return to work date must be made to the Einstein Benefits Office at least 30 days prior to the scheduled return date and is subject to approval by Einstein. My failure to return to work on or before the return date of my approved leave will be considered a voluntary resignation if no prior arrangements for an extension have been made.

Employee Signature: _____ Date: _____

Section IV: Approvals (check one)

Name	Signature	Date	Approved	Not Approved
Supervisor/Administrator:				
Division Chair/Department Director:				
VP of Human Resources:				

Note to Employee: Please complete Sections I-III, and return this form to your supervisor. If you have any questions about your leave or if circumstances change during your leave, contact the Benefits Office immediately at 718-430-2547 or by email at benefits@einsteinmed.edu.

Note to Department: Please complete Section IV, and return this form to the Benefits Office for processing.