

## Oklahoma Department of Corrections Leave Without Pay Request Form

To Be Completed By the Employee:

Name (PRINT)	State Employee ID#	Job Title
Regular Days Off	Regular Scheduled Work Hours	Facility/Unit
Start Date: _____ / _____ Time Date	Expected Date of Return: _____ / _____ Time Date	
Anticipated Duration of Leave: _____		

Reason for requesting leave without pay:

- ☐ Personal illness or injury (not workers' compensation). Medical documentation required for absences more than 3 days unless waived by the supervisor.
- ☐ Other (explain): \_\_\_\_\_

I understand that:

- Any period of leave without pay may result in a partial paycheck and placement on a supplemental payroll.
- Any period of leave without pay more than 30 continuous calendar days will affect my longevity date, credited service for retirement, and annual leave accrual date.
- Longevity checks will not be issued until there is a return to pay status or work depending on the length of absence on leave without pay.
- The employee is responsible for the payment of any insurance premiums for the employee and dependents for any pay period for which no paycheck is issued.
- Leave without pay may be cancelled at any time.
- Any absence that is not approved and any failure to return to work following leave cancellation or by the date of return indicated below may result in disciplinary action.
- Any extension of leave without pay must be requested and approved prior to the expiration of the currently approved date of return.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

To Be Completed By the Supervisor:

- ☐ LWOP Approved Employee must return to work: \_\_\_\_\_ / \_\_\_\_\_  
Time Date

This request for leave without pay has been reviewed for designation as family and medical leave: ☐ Leave has been designated as FMLA through: \_\_\_\_\_  
Date

☐ Leave has not been designated as FMLA

This request for leave without pay has been reviewed for designation as military family leave: ☐ Leave has been designated as MFMLA through: \_\_\_\_\_  
for a qualifying exigency Date

☐ Leave has been designated as MFMLA through: \_\_\_\_\_  
caregiver to a covered military service member Date

☐ Leave has not been designated as MFMLA

☐ Denied

My signature certifies that I have reviewed the above information and it is correct to the best of my knowledge. It also certifies that if the leave has been designated as FMLA &/or MFMLA then I have provided the requesting employee with the "Employer's Notice to Employee" (FMLA)/(MFMLA) – Side 2 (and/or) Side 3 of Attachment I for OP-110355.

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

Distribution: Original to Personnel File

Copy to Employee

## Employer's Notice to Employee

1. All leave designated as family and medical leave (FMLA) will be counted towards your annual 12 week entitlement.
2. Family and medical leave may be either paid or unpaid leave and you may elect to use accrued sick leave, annual leave, compensatory time (exempt employees only), or donated leave in lieu of unpaid leave. Your failure to specify that a leave request is for family and medical leave does not prevent the department from designating leave as family and medical leave when appropriate.
3. If medical certification is required or requested, failure to submit complete medical certification may result in delay or denial of leave.

Additional medical certification will be required not more often than every 30 days or when you request an extension of intermittent leave or leave that was originally approved for more than 30 days. The department may also require recertification if the circumstances described in your current certification change significantly or we receive information that casts doubt on your stated reason for absence.

4. While on any unpaid absence designated as family and medical leave, you are responsible for making premium payments for any insurance for yourself or dependents not covered by the benefit allowance(s). Failure to remit such payments may result in a cancellation of that insurance coverage. If any insurance coverage is cancelled due to your failure to make premium payments, the department will cease making any payments towards that coverage.

Checks or money orders must be made payable to the Employee Benefits Department and are due no later than the 10<sup>th</sup> day of each month at the following address:

Department of Corrections/Benefits Manager  
3400 Martin Luther King Avenue  
P.O. Box 11400  
Oklahoma City, Oklahoma 73136-0400

The department's Benefits Manager will be sending you information about any premium payments for which you are responsible. This information is also available on your Confirmation of Benefits Statement which lists all insurance in which you and your dependents are enrolled, the premiums, the amounts applied from your benefit allowance(s) and the balance.

5. If you fail to return to work following an unpaid absence during which time the department paid insurance premiums on behalf of yourself or your dependents, you will be liable for reimbursing the department for the premiums that were paid.
6. You will be required to provide the department with certification that you are fit for duty prior to returning to work for any absence that was taken for your own serious illness. This requirement will not apply to when leave is taken on an intermittent basis.

Employee Received Date: \_\_\_\_\_ Initial: \_\_\_\_\_

**Employer's Notice to Employee (MFMLA)**

1. All leave designated as military family leave (MFMLA) for a qualifying exigency will be counted towards your annual 12 week entitlement. This entitlement in combination with any use of family and medical leave (FMLA) cannot exceed 12 work weeks (480 hours) total during a 12 month period.
2. All leave designated as military family leave (MFMLA) to care for a covered military service member will be counted towards your annual 26 week entitlement. This entitlement in combination with any use of family and medical leave (FMLA) and/or any use of military family leave (MFLMA) for a qualifying exigency cannot exceed 26 work weeks (1040 hours) total during a single 12 month period. However, this will not limit the availability of leave under standard FMLA or MFMLA for a qualifying exigency during any other 12 month period.
3. Military family leave may be paid or unpaid and you may elect to use accrued sick or annual leave, or compensatory time (exempt employees only) in lieu of unpaid leave.
4. If the military service member medical certification is required or has been requested, failure to provide a completed military service member medical certification may result in denial or delay of requested leave.
5. The department may require you to provide confirmation that an instance of intermittent leave is related to the military family leave event for which the MFMLA intermittent leave was originally granted.
6. While on any unpaid absence designated as military family leave, you are responsible for making premium payments for any insurance for yourself or dependents not covered by the benefit allowance(s). Failure to remit such payments may result in a cancellation of that insurance coverage. If any insurance coverage is cancelled due to your failure to make premium payments, the department will cease making any payments towards that coverage.

Checks or money orders must be made payable to the Employee Benefits Department and are due no later than the 10<sup>th</sup> day of each month at the following address:

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3400 Martin Luther King Avenue  
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The department's Benefits Manager will be sending you information about any premium payments for which you are responsible. This information is also available on your Confirmation of Benefits Statement which lists all insurance in which you and your dependents are enrolled, the premiums, the amounts applied from your benefit allowance(s) and the balance.

7. If you fail to return to work following an unpaid absence during which time the department paid insurance premiums on behalf of yourself or your dependents, you will be liable for reimbursing the department for the premiums that were paid.

Employee Received Date: \_\_\_\_\_ Initial: \_\_\_\_\_

(R 10/20)

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