HOFSTRA UNIVERSITY
MEDICAL LEAVE REQUEST FOR FULL-TIME FACULTY

Department Recommendation

Name: _____ Hofstra ID: _____

Department: _____ Rank: _____

Years of Service: _____ Commencing Date of Leave: _____

Anticipated/Actual Return Date from Leave: _____

Explanation:

Chairperson's Signature: _____ Date: _____

Dean's Comments: Position: _____ Suffix: _____ Recommend ☐ Do Not Recommend ☐

Dean's Signature: _____ Date: _____

Provost's Office Budget Review: _____ Date: _____

Provost's Comments: Recommend ☐ Do Not Recommend ☐

Provost's Signature: _____ Date: _____

Payroll Section (To be Completed by the Office of the Provost) per Leave Period Faculty Policy Series #20

Start Date: _____ Date of Pay Reduction: _____

Anticipated End Date: _____ Amount of Pay Reduction: _____

Comments: _____

Provost Budget Approval: _____

Date: _____ Date Submitted to Payroll: _____