

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 _____

CHAIRPERSON'S SIGNATURE _____ DATE _____
RECOMMEND _____ DO NOT RECOMMEND _____

DEAN'S SIGNATURE _____ DATE _____

PROVOST'S OFFICE BUDGET REVIEW _____ DATE _____
RECOMMEND _____ DO NOT RECOMMEND _____

PROVOST'S COMMENTS _____

PROVOST'S SIGNATURE _____ DATE _____
APPROVE _____ DISAPPROVE _____

PRESIDENT'S COMMENTS _____

PRESIDENT'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 _____