State of Arkansas
Department of Finance and Administration
Request for Approved Leave Without Pay

**This form is not needed if the employee is eligible for Family Medical Leave. LWOP will only be approved in extenuating circumstances or extreme circumstances as determined by DFA Human Resources.*

Name of Employee *(Last, First, MI)*		Date
Office Name	LWOP Start Date	LWOP End Date
Personnel Number	Business Area	Personnel Area
Name of Supervisor/Manager		Phone Number

Reason for Request: ☐ Maternity ☐ Medical ☐ Other

Explanation for Request, please provide any supporting documents:
Note: During periods of LWOP it is the responsibility of the employee to pay the total cost of his/her State Employees Group Health and Life Insurance, to include the State's matching portion. When approved for LWOP, a payment schedule will be provided. Failure to comply with the due dates and premium amounts reflected on that schedule will mean immediate cancellation of the Group Health and Life Insurance. An employee may not earn leave when in a leave without pay status for 10 or more cumulative days (80 or more hours) within a calendar month.

Employee Signature	Date

Approval

Yes	No		
☐	☐	Supervisor Signature	Date
☐	☐	Administrator Signature	Date
☐	☐	Human Resources Signature	Date