



**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
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Approval

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Supervisor Signature	Date
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Administrator Signature	Date
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Human Resources Signature	Date