I wish to maintain the following benefits during my leave of absence period. To ent as calculated by the Departm an Resources for any b	It is understood that I (employee) will pay the requir	ed prem
© Group Medical Insurance © Dental Insurance		
Group Accident Insurance		
I recognize that the following wi accrue or be paid or granted during any	unpaid leave of absence period.	
1. Salary/Wage Compensation 2. Tuition Benefits 3. Vacation	n and/or Medical Leave 4. Occupational Injury	Benefits
I agree to keep my Department and the Department of Human Resources - inf Policies and such requirements are hereby accepted.	formed of any status changes. I have read applicable	University
roncies and such requirements are nereby accepted.		
	Employee Signature Date	
(Department Use Only)	Employee Signature Date	
(Department Use Only)	nent of Human Resources):	
(Department Use Only) This Leave is granted on the following basis (subject to review by the Department Complete Comple	nent of Human Resources):	
(Department Use Only) This Leave is granted on the following basis (subject to review by the Department Complete Comple	nent of Human Resources):	
(Department Use Only) This Leave is granted on the following basis (subject to review by the Department Complete Comple	nent of Human Resources): e Department or the University. c University. A position is not guaranteed by SMU.	
(Department Use Only) This Leave is granted on the following basis (subject to review by the Department of the same or equivalent position within the Employee can make application for available positions within the	nent of Human Resources): e Department or the University. c University. A position is not guaranteed by SMU.	