TAXATION & REVENUE NEW MEXICO

# REQUEST FOR LEAVE WITHOUT PAY (LWOP) FORM
## [Fillable Version (Fill Out On Computer)]

**Employee Name:** _____ **Employee ID#:** _____ **Division:** _____

**Beginning Date of Requested LWOP:** _____ **End Date of Requested LWOP:** _____

## TO BE COMPLETED BY EMPLOYEE

**NOTE: If request is because of health reasons, employee must provide TRD with contact information for healthcare professional treating the condition(s) necessitating the request.**

**Briefly describe the reason for LWOP request:**

**I authorize TRD to contact healthcare professional if the reason I cite for needing LWOP is health-related by me or a family member.**

This Form MUST be signed and dated by hand, NOT digitally.

**Employee Signature** **Date**

## IF LWOP REQUEST IS HEALTH-RELATED, HEALTHCARE PROFESSIONAL MUST COMPLETE

**Please describe the nature, severity and anticipated duration of the medical condition for the employee or family member:**

**Healthcare Professional's Address:** _____

**City, State & Zip Code:** _____

**Telephone Number:** _____ **Email Address:** _____

This Form MUST be signed and dated by hand, NOT digitally.

**Healthcare Professional Signature** **Date**

## APPROVALS

This Form MUST be signed and dated by hand, NOT digitally.

**Immediate Supervisor Signature** **Date** **Approved** ☐ **Not Approved** ☐

This Form MUST be signed and dated by hand, NOT digitally.

**Bureau Chief (Required if LWOP is up to 30 calendar days)** **Date** **Approved** ☐ **Not Approved** ☐

This Form MUST be signed and dated by hand, NOT digitally.

**Division Director (Required if LWOP request is for more than 30 calendar days)** **Date** **Approved** ☐ **Not Approved** ☐

This note and the ones above will NOT print, leaving blank spaces to sign by hand in all places.

**Cabinet Secretary (Required if LWOP request is for more than one year)** **Date** **Approved** ☐ **Not Approved** ☐

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