TAXATION & REVENUE NEW MEXICO

REQUEST FOR LEAVE WITHOUT PAY (LWOP) FORM
[Non-Fillable Version (Fill Out By Hand)]

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.

_____ _____
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:** _____

_____ _____
Healthcare Professional Signature **Date**

APPROVALS

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

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

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

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