Leave of Absence Request Form

Name:_____ PIDM:_____

Job Title:_____ Department:_____

Supervisor:_____ Employee Type:_____
(Staff, Administrator, Faculty)

My leave will begin on _____ and I anticipate being able to return to work on_____.

Any absence from work that exceeds three (3) consecutive workdays is considered a leave of absence. There are various leave types available to eligible employees. Please read the information provided below and select the leave type that you feel best describes your situation.

To be eligible for a Family Medical Leave Act (FMLA) you must:

- Have worked for the Company for a total of at least 12 months
  -AND-
- Have worked at least 1250 hours over the previous 12 months

Please place a mark in the box next to the leave type that you are requesting:

☐ **FMLA Leave of Absence for your own disability (including occupational):**
This leave type provides 12 weeks of job protection in accordance with Federal and State laws, which is tracked based on a rolling 12 month period.

- ✓ I have informed my supervisor of leave
- ✓ I understand that I must meet the eligibility requirements for this type of leave of absence and must provide supporting medical documentation.
- ✓ I understand that I am required to use my available sick and vacation during my absence.
- ✓ I understand if I am enrolled in UIW/IWHS/SACHS sponsored STD benefits I may elect to use the STD benefit instead of sick and vacation.
- ✓ I understand that my medical benefits will continue while I am using my sick and vacation benefit.
- ✓ I understand If my leave becomes unpaid, I will be required to pay my premium coverage to continue my medical benefits by submitting a check monthly to the payroll department *(please see administrator/staff guidelines book for more information.)*
- ✓ I understand that I may use my accrued vacation, sick leave benefits to supplement my UIW/IWHS/SACHS sponsored STD benefits or workers comp lost wage benefits (up to 100% of my regular weekly wages). Must have approval by Human Resources department to supplement sick and vacation.
- ✓ I understand that my leave can be taken continuously or intermittently.
- ✓ **Pregnancy Leave Only**: I understand that a newborn leave must be completed within 12 months after the birth, adoption or placement of the child. And my leave can only be taken continuously.

☐ **FMLA Leave of Absence in order to care for an approved family member:**
This leave type provides 12 weeks of job protection in accordance with Federal and State laws, which is tracked based on a rolling 12 month period.

I am requesting this time off for my: (please check one)
☐ Spouse ☐Parent ☐Child

- ✓ I have informed my supervisor of leave
- ✓ I understand that I must meet the eligibility requirements for this type of leave of absence and must provide supporting medical documentation.
- ✓ I understand that I am required to use my available vacation time during my absence.
- ✓ I understand that my medical benefits will continue while I am using my vacation benefit.
- ✓ I understand If my leave becomes unpaid, I will be required to pay my premium coverage to continue my medical benefits by submitting a check monthly to the payroll department *(please see administrator/staff guidelines book for more information.)*
- ✓ I understand that my leave can be taken continuously or intermittently.

☐ **Military-related FMLA Qualifying Exigency leave:**
This leave is available to eligible employees while the employee's spouse, child or parent is on active duty or call to active duty. This leave type provides 12 weeks of job protection in accordance with Federal and State laws, which is tracked based on a rolling 12 month period.

I am requesting this time off for my: (please check one)
☐ Spouse ☐Parent ☐Child

- ✓ I have notified my supervisor of my leave
- ✓ I understand that I must meet the eligibility requirements for this type of leave of absence.
- ✓ I understand that I am required to complete the pertinent certification form within 15 days of requesting a qualifying exigency leave.
- ✓ I understand that I am also required to provide a copy of the covered military member's active duty orders, or documentation of the call to active duty.
- ✓ I understand that a qualifying exigency leave is available only when the covered military member is a member of the National Guard or Reserve or a retired member of the Regular Armed Forces or Reserve and is called to duty in that capacity. It is not available when the covered military member is a member of the Regular Armed Services.
- ✓ I understand that I am required to use my available vacation time during my absence.
- ✓ I understand that my medical benefits will continue while I am using my vacation benefit.
- ✓ I understand If my leave becomes unpaid, I will be required to pay my premium coverage to continue my medical benefits by submitting a check monthly to the payroll department *(please see administrator/staff guidelines book for more information.)*
- ✓ I understand that my leave can be taken continuously or intermittently.

☐ **Military- Related FMLA caregiver leave**
FMLA leave to care for a current member of the Guard, Reserves or Regular Armed Forces who has incurred an injury or illness in the line of duty may take up to 26 workweeks of job protection during a 12 month period.

I am requesting time off to care for my: (please check one)
☐ Spouse ☐Parent ☐Child ☐next of kin

- ✓ I have notified my supervisor of my leave
- ✓ I understand that I must meet the eligibility requirements for this type of leave of absence.

- ✓ I understand that I am required to complete the pertinent certification form within 15 days of requesting this type of leave.
- ✓ I understand that I am required to use my available vacation time during my absence.
- ✓ I understand that my medical benefits will continue while I am using my vacation benefit.
- ✓ I understand If my leave becomes unpaid, I will be required to pay my premium coverage to continue my medical benefits by submitting a check monthly to the payroll department *(please see administrator/staff guidelines book for more information.)*
- ✓ I understand that my leave can be taken continuously or intermittently.

☐ **Personal Medical Leave of Absence (non-FMLA)**

Full time employees who do not qualify for leave under FMLA may apply for medical leave for your own or a family member's serious health condition.

To be Eligible for Personal Medical Leave employee must have 6 months of continuous employment.

This leave type provides a maximum of 12 weeks leave, which is tracked, based on a "rolling" 12 month period.

- ✓ Must be taken as a continuous basis only.
- ✓ I understand that I must meet the eligibility requirements for this type of leave of absence.
- ✓ I understand that I am required to complete the pertinent certification form within 15 days of requesting a personal medical leave.
- ✓ Must take sick and vacation
- ✓ Will stop accruing sick and vacation benefits after 30 days on personal leave.
- ✓ I understand that my medical benefits will continue while I am using my vacation, sick benefit.
- ✓ I understand If my leave becomes unpaid, I will be required to pay my premium coverage to continue my medical benefits by submitting a check monthly to the payroll department *(please see administrator/staff guidelines book for more detailed information.)*

PLEASE NOTE: The University retains the sole discretion to interpret provisions of the leave policy and may change its policies and practices at any time for any reason.