THE UNIVERSITY OF UTAH

Human Resources Division
420 Wakara Way, Suite 105 Salt Lake City, Utah 84108
Fax: (801) 585-7375

Request for Leave Under the Family and Medical Leave Act of 1993 ("FMLA")

Employee Information

Name: _____ Employee ID # _____

Address: _____ City: _____ St: _____ Zip: _____

Email Address: _____ Home Phone: _____

Department: _____ Work Phone: _____

Supervisor's Name: _____ Supervisor's Phone Number: _____

Payroll Reporter's Name: _____ Payroll Reporter's Phone Number: _____

Reason for FMLA Request

- □ Maternity, Paternity, Adoption, or Foster Care Placement
- □ Serious Health Condition *(a completed Certification of Health Care Provider is required)*
  - □ Employee
  - □ Employee's Spouse
  - □ Employee's Parent
  - □ Employee's Child *(must be under the age of 18 or disabled)*

Use of Vacation Accruals

In accordance with University of Utah Policy, an employee must substitute any accrued paid leave, (e.g., sick and vacation) for any unpaid Family and Medical Leave time, except that an employee may retain up to ten (10) days of vacation leave. Upon exhaustion of any accrued leave, the remainder of any Family and Medical Leave will be unpaid.

□ I wish to use all available vacation accruals

□ I wish to retain _____ hours/days (circle one) of vacation

Begin Date Of Leave: _____ End Date If Known: _____

If leave is for a Serious Health Condition, the dates stated by the Health Care Provider will be used.

Employee Certification

I hereby certify the following:

- I have a need for leave for a reason that may qualify under the FMLA.
- I understand that I must provide advance notice of my need for leave (at least 30 days if my need is foreseeable and as soon as possible and practical if my need is not foreseeable); and that I must comply with my department's usual and customary notice requirements if I will be unable to work, absent unusual circumstances.
- I understand that I must schedule appointments outside working hours, if available; otherwise, I must make a reasonable effort to schedule them at a time that does not unduly disrupt the business operations of my department.
- In the event I need leave for a Serious Health Condition, I understand I must submit a completed Certification of Health Care Provider prior to approval of my request for leave. I understand that my request for leave may be delayed or denied if the Certification is not complete or does not provide sufficient information. I authorize a representative of the Division of Human Resources to contact my Health Care Provider for purposes of clarification and/or authentication of my Certificate of Health Care Provider.

_____ _____

Signature of Employee **Date**

Supervisor Acknowledgement

I have reviewed this Request and discussed the proposed leave with the employee. If possible, the requested leave has been scheduled for a time that will not unduly disrupt the business operations. My signature confirms my knowledge of the employee's request for leave, but does not approve the employee's request for leave.

Supervisor Signature:_____ Date:_____