REQUEST FOR LEAVE OF ABSENCE (Form 1001)

Section 1: PERSONAL INFORMATION (Staff Member completes Sections 1 and 2 and returns completed form to Supervisor/Manager)		
Last Name:	**First Name:**	**Duke Unique ID:**
Home Address:	**Phone (Work):**	**Department:**
Date Submitted:	**Phone (Home):**	**Job Title:**
Signature:	**E-mail:**	**CSD/Hire Date:**

Section 2: STAFF MEMBER: Check the type of leave, supply the required information in writing, and provide attachments as indicated.

Family Medical Leaves (required medical certifications must be returned within 15 days of receipt).

□	**Employee Illness**	**Certificate of Health Care Provider (Form 1002-E)**
□	**Child/Parent/Spouse Illness**	**Certificate of Health Care Provider for Family Member's Illness/Injury (Form 1002-F)**
□	**Maternity**	**Certificate of Health Care Provider (Form 1002-E)**
□	**Paternity**	**Certificate of Health Care Provider (Form 1002-F) (Must be taken within one year of birth)**
□	**Adoption/Placement of Foster Child**	**Letter of Placement (Must be taken within one year of placement)**
□	**Military Caregiver**	**Certification for Serious Illness or Injury of Covered Service Member (DOL WH-385-V)**
□	**Military Exigency**	**Certification of Qualifying Exigency (DOL WH-384)**

Personal Leaves (not FMLA eligible or not FMLA related) – Please check all that apply.

□	**Educational**	**Letter of Acceptance from Educational Institution**
□	**Medical (non-FMLA)**	**Certificate of Health Care Provider (Form 1002-E)**
□	**Military (non-FMLA)**	**Department of Defense Orders**
□	**Maternity (not eligible for FMLA), including Paid Parental Leave**	**Certificate of Health Care Provider (Form 1002-E)** **Primary Caregiver Affidavit for Paid Parental Leave**
□	**Paid Parental Leave (non-maternity)**	**Certificate of Health Care Provider (Form 1002-E or 1002-F)** **Primary Caregiver Affidavit for Paid Parental Leave**
□	**Other Personal**	**Explanation of Request**

I request that my leave begin on _____ and end on _____. (If necessary, give approximate dates.)

Section 3: SUPERVISOR/MANAGER/DEPARTMENT HR: Complete this section		
Name (Print):	**E-mail:**	
Signature:	**Phone:**	**Date:**

Name(s) and E-mail(s) of any others to receive Determination Form:

Check entity where Staff Member is employed:

□ **DUH – Duke University Hospital**	□ **DUHS – Company 20, Corporate Services**	□ **DPC – Duke Primary Care**
□ **AHS/DASC**	□ **University – includes SOM, SON, DCRI**	□ **PDC**
□ **DRH – Duke Regional Hospital**	□ **CFL – Health & Wellness**	□ **DHCH – Duke Homecare/Hospice**
□ **DRaH – Duke Raleigh Hospital**	□ **Labco – DUHS Clinical Labs**	□ **PRMO**

If this leave is for a Family Medical Leave:

(1) Has Staff Member had absences counted towards FMLA entitlement in the past 12 months? □ **YES** □ **NO**
Provide dates/hours which have already been applied towards FMLA, along with supporting documentation

Dates: From _____ to _____ Total hours of FMLA utilized to date: _____

(2) If approved, will this leave be taken on an intermittent basis? □ **YES** □ **NO** *(Not available for adoption, placement in foster care or Paternity leave; only available for maternity leave if medically necessary)*

(3) Leave dates approved by EOHW Determination Form From _____ To _____