

# Family and Medical Leave of Absence Application Form

When the need for a leave of absence is foreseeable, you are required to request the leave 30 days in advance. Examples of foreseeable events include planned medical treatment or your child's birth. For unforeseen events, such as accidental injury causing a serious health condition, premature birth or sudden change in your health, you are required to request the leave as soon as it is possible and practical to do so. The Medical School's Family and Medical Leave of Absence Policy contains an explanation of your rights and obligations regarding leaves of absence under the Medical School's Policy and the FMLA.

Name: \_\_\_\_\_ Employee ID # \_\_\_\_\_

Address: \_\_\_\_\_  
Street / P.O. Box City Zip Code

Home Phone: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Department: \_\_\_\_\_ Position: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Date of Hire: \_\_\_\_\_

## The reason you are requesting a leave of absence is (check the appropriate box):

- EMPLOYEE MEDICAL LEAVE – *your own serious health condition that prohibits you from performing the essential function(s) of your job.*
- FAMILY MEDICAL LEAVE – *the need to care for your spouse, child or parent who has a serious health condition.*
- NEW CHILD LEAVE – *the birth of your child or the placement of a child with you for adoption or foster care.*

***[If you experience a family status change during your leave of absence, as described below, you must complete a Benefits Enrollment/Change Form within 31 days of the family status change in order to add/delete a dependent under your health care plan:***

- ***Marriage, divorce, legal separation, or annulment***
- ***Losing a spouse or dependent through death or if a dependent becomes ineligible***
- ***Changes in your, your spouse's or your dependent's employment status***
- ***Your spouse's health Open Enrollment***

***You must complete a Benefits Enrollment/Change Form within 62 days for the birth or adoption of a child.]***

## Have you taken a leave of absence under this Policy during the past twelve months?

Yes  No If yes, when was the last such leave? \_\_\_\_\_

## If your spouse works for the University, has your spouse taken a leave of absence under this Policy during the past twelve months?

Yes  No If yes, when was the last such leave? \_\_\_\_\_  
 Not applicable

## If you are requesting NEW CHILD LEAVE, please answer the following questions:

Requested Leave Time: From \_\_\_\_\_ To \_\_\_\_\_

What is the:  anticipated or  actual date of birth or placement? \_\_\_\_\_

## If you are requesting a FAMILY MEDICAL LEAVE or EMPLOYEE MEDICAL LEAVE, please answer the following questions:

Have you submitted the necessary medical certification with this form?  Yes  No

Are you requesting full-time leave?  Yes  No

**If you are requesting full-time leave, please answer the following questions:**

What is your requested leave time? From \_\_\_\_\_ To \_\_\_\_\_

What other dates would be appropriate for the leave? \_\_\_\_\_

**Are you requesting intermittent or reduced schedule leave?**       Yes  No

**If yes, please answer the following questions:**

Why is it medically necessary for you to have intermittent or reduced schedule leave? \_\_\_\_\_

For which dates, times or schedules are you requesting leave? \_\_\_\_\_

For which dates, times, or schedules would be appropriate for your intermittent or reduced schedule leave?

What employment positions are available that you believe would more easily accommodate your requested leave? \_\_\_\_\_

**By signing below, you are certifying that you have read the Medical School's Family and Medical Leave of Absence Policy and that you agree to abide by the requirements of the Policy. Failure to abide by these requirements may result in delay or denial of your leave, or it may result in disciplinary action up to and including termination of your employment. By signing, you also affirm that you have been and will be truthful and sincere in your request for a leave of absence.**

Date: \_\_\_\_\_ Employee Signature: \_\_\_\_\_

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**This section to be completed by Department**

Has this employee completed 12 months of service?       Yes     No  
Has this employee worked more than 1250 hours in the past 12 months?       Yes     No  
Has this employee been on FMLA in the last 12 months?       Yes     No  
Has this employee exhausted 12 weeks of FMLA leave?       Yes     No

Approved:

- Enter approved leave online in the payroll system (HRMS).
- Send a copy of the completed response letter, application and medical certification (if applicable) to Human Resources, Campus Box 8002.

Disapproved (Explanation)\* \_\_\_\_\_

Date: \_\_\_\_\_ Supervisor Signature \_\_\_\_\_

\*Contact the Human Resources Office.