

Family and Medical Leave (FMLA) Request Form

Effective 08/2011
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- 1) Complete first page of form and sign on page two
- 2) Submit to supervisor for signature, accrual information and HRA signature
- 3) Have Certification of Health Care Provider form completed (do not submit to supervisor)
- 4) Submit all forms to HRS Absence Management (via email at tkb@uchicago.edu or fax to 773.702.6098) 30 days prior to FMLA leave start date or as soon as need for absence is known

Before completing this form, please review the HRS 522 - FMLA Policy at <http://hrservices.uchicago.edu/fpg/policies/500/p522.shtml> for eligibility requirements and complete conditions of an FMLA leave of absence.

PLEASE PRINT

Biweekly Monthly

Name: _____ SS#: xxx-xx-_____ Phone Number: _____
 Address: _____ City, State Zip: _____ Date of Birth: _____
 Job Title: _____ Dep. Name: _____
 Email address (for communication with HRS while on leave): _____

I HEREBY REQUEST FMLA LEAVE OF ABSENCE AS FOLLOWS:

REASONS FOR LEAVE OF ABSENCE: (check one)

- | | |
|--|---|
| <input type="checkbox"/> Birth/Care of Newborn | <input type="checkbox"/> Placement/Adoption/Foster Care |
| <input type="checkbox"/> Health condition | <input type="checkbox"/> Health condition: <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> parent |
| <input type="checkbox"/> Covered service member injury | <input type="checkbox"/> University-registered domestic partner |
| <input type="checkbox"/> Qualifying exigency | |

INTERMITTENT LEAVE No Yes _____
 If yes, indicate frequency and duration estimates

LEAVE TO BEGIN DATE: _____ LEAVE TO END DATE: _____

I HEREBY REQUEST THE FOLLOWING BENEFITS BE CONTINUED DURING AN UNPAID FMLA LEAVE:

- | | | |
|--|---|--|
| <input type="checkbox"/> Medical Insurance | <input type="checkbox"/> Life Insurance | <input type="checkbox"/> Personal Accident Insurance |
| <input type="checkbox"/> Dental Insurance | <input type="checkbox"/> Long-Term Disability | |

Approval of an FMLA leave requires a specific explanation from your health care provider. Please ensure HRS receives your **health care provider's certification form within 15 days of HRS's receipt of your completed request form or the first day of your leave (if notice was not practicable).**

I request that HRS apply the following breakdown of accrued vacation and/or personal holidays for my FMLA leave. (You must use all but 5 days of your vacation and personal holidays combined)
 # of vacation days # of personal holidays Use all of both

I have reviewed the University's FMLA policy. I affirm that the information provided above accurately represents the conditions necessitating my leave. I understand that failure to obtain my supervisor's signature prior to submitting this form to HRS will result in the delayed processing of my request. I am not required to provide details about my medical condition to my supervisor.

Employee's Signature

Date

I agree to adhere to the requirements of the Family and Medical Leave Act and understand that confidentiality prohibits me from asking for any medical information from employees.

Supervisor's Signature

Supervisor Email

Date

HRA/Dept Admin Signature

HRA/Dept Admin Email

Date

ACCRUALS:

SICK _____

PERSONAL _____

VACATION _____

-----To Be Completed by HRS Absence Management only -----

Leave Approved: _____

Leave Denied: _____

Absence Management

Date