Medical Leave/FMLA Request Form

This form should be completed at least 30 days in advance of the need for a medical leave. If the 30 day advance notice is not possible, notice should be provided as soon as possible.

<table>
<thead>
<tr>
<th>Employee Name: First name Last name</th>
<th>Dept/Job Title</th>
<th>Ext:</th>
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Home Address: Street, City, State, Zip Code

Status: (Please circle) Administrative Faculty Clerical Full-Time Part-Time

Temporary

Hire Date: Supervisor: Ext.

Reason for medical leave request. Please check one and complete.

- **Maternity**—Expected date of birth __________________
  Do you plan to take additional family leave time (using vacation or unpaid time) after you are medically released from your doctor to return to work? Yes No
  If yes, number of vacation days to be used _______ and number of unpaid days to be used _________.
  This information should be used by the department to report sick, vacation and unpaid time.
  Please notify Melody Cook Disability Claims Mgr. x6677 and your supervisor if the number of vacation or unpaid days change after completing this form.

- For a **serious health condition or medical procedure** that makes me unable to perform my job.
  Leave to start: ____________________ Expected period of disability: ____________________

- **Serious health condition** affecting your ___ spouse, ___ child, ___ parent, for which you are needed to provide care.
  Leave to start: ____________________ Expected length of leave ____________________

- **Call to Duty Leave**: Eligible employees may take up to 12 weeks on unpaid leave for a “qualifying exigency”, for the employee’s spouse, son, daughter or parent in the National Guard or the Reserves being notified of an impending call or order to active duty.
  Leave to start: ____________________ Expected length of leave ____________________

- **Military Caregiver Leave**: Eligible employees may take up to 26 weeks of unpaid leave to care for a spouse, son, daughter, parent or next of kin service member with a serious injury or illness incurred in the line of duty on active duty.
  Leave to start: ____________________ Expected length of leave ____________________

Employee’s signature Date
Supervisor’s signature Date

This form must be signed by both employee and supervisor. Please submit completed form to:
  Melody Cook Disability Claims Manager, Human Resources, Koren Bldg. or fax to 412-396-2236