

Leave of Absence Request Form

Employee Information

Name: _____ UID / Date of Hire: _____
 Address: _____ City: _____ St: _____ Zip: _____
 Email Address: _____ Home Phone: _____
 Department: _____ Work Phone: _____
 Supervisor's Name: _____ Business Manager's Name: _____

Select the leave type(s) that apply: FMLA Parental Military Disability Workers Comp Unpaid LOA

Reason for FMLA Leave (check one for each section, if applicable)

Maternity, Paternity, Placement for Adoption, or Foster Care.
 The expected date of birth, placement for adoption or foster care _____
 My own serious health condition that makes me unable to perform my job.
 Care of my family member who has a serious health condition.
 Family member's name _____
 Relationship of the person to the employee _____
 Qualifying Exigency Leave

**Family members include parent, son, daughter, or spouse of the employee, see family member definition under FMLA Definitions for more information.*

This requested leave will be:

Intermittent Continuous Reduced Work Schedule

Payment During Leave (check all that apply)

If eligible, I elect military leave (up to 31 days per year, part time employees are adjusted to an equivalent of this)

If eligible, I elect parental leave (up to 3 weeks for father, up to 6 weeks for mother).

I have no paid leave available, this leave will be unpaid. *If you wish to maintain benefits, please review the process for benefit premiums during paid leave or contact hr-leave@wright.edu.*

All paid leave **must be exhausted prior to an unpaid leave status.*

All paid leave **must be exhausted in order to receive Unum approved disability payments.*

Begin Date of Leave: _____

End Date of Leave: _____

Employee Certification

I understand that:

- The maximum FMLA leave allowed is 12 weeks in any 12-month period, if FMLA exhausts, the employee will need to contact the Office of Equity and Inclusion to apply for a reasonable accommodation for the leave related to their medical condition.
- This leave will run concurrently with all other applicable leave types (e.g. sick leave, worker's comp, parental leave, disability leave).
- I am eligible to continue my benefits and that, if my leave is unpaid, I will be responsible for remitting the premiums to the Department of Human Resources.
- I have the right, upon return from leave to be returned to my original position or an equivalent position (with equivalent pay, benefits and other terms of employment).
- If I am requesting intermittent leave or a reduced work schedule, and my absences are foreseeable in their nature, I must provide a listing of the schedule being requested.
- I must give notice 30 days in advance for a leave that is foreseeable (e.g., surgery, pregnancy/delivery) and I must give notice within 2 days of the need for leave (or as soon as practicable) when the need for leave is not foreseeable (e.g. an emergency).
- I understand that I must follow established departmental call-in procedures and inform my supervisor or his/her designated representative that I am claiming FMLA when calling in.

Signature of Employee

Date

Supervisor/Department Acknowledgement

My signature confirms my knowledge of the employee's request for leave, but does not approve the employee's request for leave.

 Supervisor's or Department Representative's acknowledgement (Print/Sign)

 Date