



REQUEST FOR MEDICAL LEAVE OF ABSENCE

Name: _____ SSN: _____

Title: _____ Dept: _____

I hereby request a medical leave of absence as follows:

Beginning Date: _____ Ending Date: _____

(Per Treating Licensed Physician Statement/Medical Leave Verification Form)

Purpose of Leave:

- Birth of child and to care for new-born child
Placement of child for adoption or foster care, and to care for adopted child or child in foster care
The care of spouse, child or parent with a serious health condition
Employee's serious health condition which makes employee unable to perform the functions of employee's job

I understand that while on an approved Medical Leave of Absence, I am required to continue to pay my respective proportionate share of health/life/hospitalization/drug insurance coverage premium cost. I further understand that if the approved leave continues after 12 consecutive months, I may be required to pay the full cost of coverage (employee and employer's share).

I further understand that in order to continue insurance coverage, I am required to submit to my employer each month a PEIA Statement of Necessity for Medical Leave of Absence certifying I am unable to return to work/duty. The due date for this statement is every 30 days from the beginning date of medical leave of absence. Failure to supply this form will result in the termination of insurance coverage and possible termination of employment. (This form will be provided to you by the Human Resources Department).

I further understand that prior to my return to work, I am required to submit to my employer a Return to Work Authorization /Medical Release Form from the treating licensed physician. (This form will be provided to you by the Human Resources Department).

I further understand that the extent of this leave will count toward entitlement of the Family and Medical Leave Act of 1993 (FMLA), as applicable, which provides up to 12 weeks job-protected leave to eligible employees for certain family and medical reasons. See the attached publication by the U.S. Department of Labor entitled "Your Rights Under the Family and Medical Leave Act of 1993."

I further understand that any extension of this leave must be requested in writing by completing a new Request for Medical Leave of Absence Form and obtain a new Treating Licensed Physician Statement/Medical Leave Verification Form, and be submitted for the President's approval prior to the expiration of this approved leave.

I understand that approval of this Request for Medical Leave does not guarantee payment of wages, leave or other compensation and that all policies, rules, and laws in regard to leave payment apply.

IMPORTANT

This request form MUST be accompanied by a completed Treating Licensed Physician Statement/Medical Leave Verification Form (attached).

Employee's Signature _____ Date _____

I recommend approval of this leave ___Yes ___No

Supervisor's Signature _____ Date _____

I recommend approval of this leave ___Yes ___No

Unit Administrator's Signature _____ Date _____

I recommend approval of this leave ___Yes ___No

Human Resources Administrator's Signature _____ Date _____

Approved Denied

Executive Vice President's Signature _____ Date _____

RESERVED FOR HUMAN RESOURCES DEPARTMENT USE ONLY

DO NOT WRITE IN THIS BOX

I. Date leave commenced _____ Expected end date _____
(Per Treating Licensed Physician Statement/Medical Leave Verification Form)

II. Non-Faculty Employees Only:

1. Verification of Leave Balances as of _____ (Date)

Annual Leave _____ days

Sick Leave _____ days

2. Exhaustion of all sick/annual leave as of _____
(Date & Time)

3. Date Catastrophic Leave Request Form Sent _____
(30 days prior to expiration of leave)

4. Applied for Catastrophic Leave? YES NO N/A

III. Date notification letter sent: _____

IV. Verification of receipt of monthly physician's statement:

<u>Month</u>	<u>Date Rec'd in HR</u>	<u>Month</u>	<u>Date Rec'd in HR</u>
<i>(List below)</i>		<i>(List Below)</i>	

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

V. Verification of receipt of monthly insurance premiums:

<u>Month</u>	<u>Date Rec'd in HR</u>	<u>Month</u>	<u>Date Rec'd in HR</u>
<i>(List below)</i>		<i>(List Below)</i>	

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

VI. Date of Actual Return to Work/Duty: _____

OR

Date extension of leave requested: _____