

# REQUEST FOR LEAVE OF ABSENCE

## I. FAMILY MEDICAL LEAVE

I request a leave under the provisions of the Family and Medical Leave Act of 1993 for the following reason:

- a. \_\_\_\_\_ Personal Illness or Injury
- b. \_\_\_\_\_ The birth of a child
- c. \_\_\_\_\_ To care for a newborn child
- d. \_\_\_\_\_ To care for a newly adopted child
- e. \_\_\_\_\_ The placement in my home of a foster child
- f. \_\_\_\_\_ To care for one of the following (please check one):
  - Spouse
  - Child
  - Parent

## II. OTHER LEAVE OF ABSENCE

- a. \_\_\_\_\_ Personal
- b. \_\_\_\_\_ Worker's Compensation
- c. \_\_\_\_\_ Military
- d. \_\_\_\_\_ Extended Family and Medical Leave of Absence (has exhausted original 12 weeks of FMLA)
- e. \_\_\_\_\_ Other

## III. SOS ONLY

SOS have the option of saving one week of sick time for personal leave or one week vacation time for the care of a family member. By saving this one week, the employee understands that their leave may put them in an unpaid situation.

- I would like to save one week of sick/vacation time (please circle one):    **YES**                      **NO**

*\*\*\*I understand that my leave balance can be viewed at DU Self Service.\*\*\**

In the event that an employee exhausts all paid time off and after a leave from work that exceeds 5 workdays, an employee can make a request for leave days through the Leave Donation program. Inquire at the Office of Human Resources for more information.

## IV. TO BE COMPLETED BY ALL STAFF

I need this leave beginning \_\_\_\_\_ and I expect the leave to continue until on or about \_\_\_\_\_.

**TODAY'S DATE:** \_\_\_\_\_ **NAME:** \_\_\_\_\_

Please return this form to the Office of Human Resources, Doane 307, Doane Administration Building.

**NOTE:**    *You will be required to submit a physician's certification of your own or of a family member's serious illness.*

### FOR OFFICE USE ONLY

HR APPROVAL: \_\_\_\_\_ DATE: \_\_\_\_\_