The University of Chicago
6054 South Drexel Avenue
Chicago, Illinois 60637

THE UNIVERSITY OF CHICAGO | Human Resources

Family and Medical Leave (FMLA) Request Form

1) Have Certification of Health Care Provider form completed (do not submit to supervisor)
2) Sign where indicated and submit all forms to HR-Leave Administration (via email at leaveadministration@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 HR 522 - FMLA Policy at http://humanresources.uchicago.edu/fpg/policies/500/p522.shtml for eligibility requirements and complete conditions of an FMLA qualifying leave.

EMPLOYEE INFORMATION TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT)

Biweekly ☐ Monthly ☐

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

I HEREBY REQUEST FMLA LEAVE OF ABSENCE AS FOLLOWS:

REASONS FOR LEAVE: (check one)

Employee's Own Health:

____ Birth/Care of Newborn
____ Health condition
____ Covered service member injury

Family Leave:

____ Parental/ Paternity Leave/ Placement/Adoption/Foster Care
____ Health condition: ____ spouse ____ child ____ parent
____ University-registered domestic partner
____ Qualifying exigency

INTERMITTENT LEAVE ☐ No ☐ Yes

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

I hereby request to Continue (C) / Waive (W) the following benefits during my unpaid FMLA leave as indicated by the mark "C/W". You must initial and date this section in order for changes to take effect.

_____ Medical Insurance
_____ Dental Insurance
_____ Life Insurance
_____ Long-Term Disability
_____Vision Insurance
_____ Personal Accident Insurance

***_____Initial _____Date**

Approval of an FMLA leave requires a specific explanation from a certified/ licensed health care provider. Please ensure Leave Administration receives the correct version of the health care provider's certification form within 15 days of HR-Leave Administration's receipt of your completed request form or the first day of your leave (if notice was not practicable). ***Incomplete submissions, i.e., missing forms, insufficient information, etc., will not be processed.**

Accrual Election Option (You must use all but 5 days of your vacation and personal holidays combined before the leave can be unpaid). *If your leave is due to your own health condition, sick time will be applied first. **I request that HR-Leave Administration apply the following breakdown of accrued vacation and/or personal holidays for my FMLA leave:**

___ # of vacation days ___ # of personal holidays ___ Use all of both OR ____Save 5 days

☐ **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 HR-Leave Administration will result in the delayed processing of my request. I am not required to provide details about my medical condition to my supervisor.**

PLEASE NOTE:

- If you have a qualifying life event, (e.g. birth/adoption of a child or children) during your FMLA Leave and you wish to enroll your new child(ren) in a University of Chicago medical plan; you must do so within 31 days of the date of birth/adoption (event date) using Workday.
- If you have waived benefits during an unpaid FMLA Leave, you must complete enrollment changes within 31 days of your return to work date (event date) in Workday.
- If you are applying for an unpaid FMLA leave and you are enrolled in Long Term Care insurance, you must contact Genworth at 800-416-3624 to arrange for the payment of your monthly premiums.

_____ _____
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 HR-Leave Administration only ----------

Leave Approved: _____ Leave Denied: _____

_____ _____
HR-Leave Administration Date