THE UNIVERSITY OF **CHICAGO** | Human Resources

Leave Request Form

1) Submit completed and signed "Form" to HR Leave Administration via email at leaveadministration@uchicago.edu or fax to 773-702-6098, 30 days prior to leave start date or as soon as need for absences is known.
2) Have the "Healthcare Providers Statement" completed and submitted directly to HR Leave Administration.

Employee's Information

Employee's Name: _____   SSN: XXX-XX-_____   Date of Birth: _____

Home Address: _____

City: _____   State: _____   Zip Code: _____   Home Phone: _____

Email Address (for communications with HR Administration while on leave): _____

Job Title: _____   Department: _____   Hours worked/week _____

Hire Date: _____   Pay Type: ☐ Monthly   ☐ Biweekly

Details about your Leave Request

Leave Type (check all that apply):

☐ FMLA ___Save 5 Days **OR** ___Use all Accruals   FMLA Intermittent Leave ☐ Yes   ☐ No

☐ Short-Term Disability   ☐ Parental Leave   ☐ Medical Leave

☐ Personal Leave (Please provide a reason for your personal leave request) _____

*Please note: If requesting a FMLA leave you will need your healthcare provider to complete the applicable Form 380-E, 380-F, 384, 385, 385-V.

Reason for Leave:

☐ Health condition (self)

☐ To care for: ☐ Spouse   ☐ Child   ☐ Parent   ☐ Domestic Partner   ☐ Civil Union Partner

☐ Maternity/ Paternity Leave/ Parental Leave

☐ Adoption   ☐ Foster Care Placement

☐ Covered service member injury

☐ Qualifying Exigency (due to family being called to duty) : ☐ Spouse ☐ Child ☐ Parent ☐ Domestic Partner ☐ Civil Union Partner

Leave begin date: _____   Return to work date: _____

I have reviewed the University's policy for the leave that I am requesting. 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 will result in the delayed processing of my request. I am not required to provide details about my medical condition to my supervisor.

If I have a qualifying life event (e.g. birth/adoption) during my leave and wish to enroll your new child(ren) in a University of Chicago Medical plan; I must do so within 31 days of the date of birth/adoption using Workday.

Employee's Signature: _____   Date: _____

HR Administrator & Supervisor (please sign and return to leave administration)

I have reviewed the University's policy for the leave that is being requested. I affirm that the information provided above accurately represents the condition necessitating the leave. I acknowledge that I cannot request details about an employee's medical condition.

Supervisor Signature: _____   Email: _____   Date: _____

HR Administrator Signature: _____   Email: _____   Date: _____

HR Leave Administration

Signature: _____   Date: _____   ☐ Approved   ☐ Denied