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

THE UNIVERSITY OF CHICAGO

Family and Medical Leave (FMLA) Request Form

1) Complete first page of form and sign on page two
2) Submit to supervisor for signature, accrual information and HRA signature
3) Have Certification of Health Care Provider form completed (do not submit to supervisor)
4) Submit all forms to HR- Leave Administration (via email at crichardson1@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://hrservices.uchicago.edu/fpg/policies/500/p522.shtml for eligibility requirements and complete conditions of an FMLA leave of absence.

PLEASE PRINT

Biweekly ☐ Monthly ☐

Name: ______________________ SS#: xxx-xx-__________ Phone Number: ______________
Address: ______________________ City, State Zip:______________ Date of Birth:____________
Job Title: ______________________ Dep. Name: ______________________________
Email address (for communication with HR while on leave): ______________________________

I HEREBY REQUEST FMLA LEAVE OF ABSENCE AS FOLLOWS:

REASONS FOR LEAVE OF ABSENCE: (check one)

____ Birth/Care of Newborn
____ Health condition
____ Covered service member injury
____ Qualifying exigency
____ Placement/Adoption/Foster Care
____ Health condition: ____ spouse ____ child ____ parent
____ University-registered domestic partner

INTERMITTENT LEAVE ☐ No ☐ Yes ______________________________
If yes, indicate frequency and duration estimates

LEAVE TO BEGIN DATE: __________ LEAVE TO END DATE: __________

I HEREBY REQUEST THE FOLLOWING BENEFITS BE CONTINUED DURING AN **UNPAID** FMLA LEAVE:

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

Approval of an FMLA leave requires a specific explanation from your health care provider. Please ensure HR receives your **health care provider's certification form within 15 days of HR's receipt of your completed request form or the first day of your leave (if notice was not practicable).**

_____ I request that HR apply the following breakdown of accrued vacation and/or personal holidays for my FMLA leave. (You must use all but 5 days of your vacation and personal holidays combined)
____ # of vacation days ____ # of personal holidays ____ Use all of both

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

______________________________ ______________
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: ________

_______________________________ _______________________
Leave Administration Date