Danforth Campus Family and Medical Leave of Absence Application Form (and Departmental Leave when applicable)

When the need for a leave of absence is foreseeable, you are required to request the leave 30 days in advance. Examples of foreseeable events include planned medical treatment or your child's birth. For unforeseen events, such as accidental injury causing a serious health condition, premature birth or sudden change in your health, you are required to request the leave as soon as it is possible and practical to do so. When FMLA leave is needed to care for an immediate family member or your own illness, and is for planned medical treatment, that treatment must be scheduled so that it will not be unduly disruptive. The Family and Medical Leave of Absence Policy contains an explanation of your rights and obligations regarding leaves of absence under the Policy and the FMLA. Departmental Leave is available to employees who are unable to work for their own medically related reasons and provides a total of 6 months of job protected leave concurrent with FMLA. Please refer to the Departmental Leave Policy for a complete explanation of eligibility. Both pages of this application must be completed

Name: ______________________________ Employee ID #: ______________________________

Home Address: ____ Home Phone: ________________
Street / P.O. Box City Zip Code

Department: ______________________________ Position: ______________________________

Supervisor: ______________________________ Date of Hire: ______________________________

What is your requested leave time?

From: ______________________________ To: ______________________________

The reason you are requesting a leave of absence is (check the appropriate box):

☐ EMPLOYEE MEDICAL LEAVE – *your own serious health condition that prohibits you from performing the essential function(s) of your job.*

☐ FAMILY MEDICAL LEAVE – *the need to care for your spouse, child or parent who has a serious health condition.*

☐ NEW CHILD LEAVE – *to be with your child following the birth or the placement of a child with you for adoption or foster care.* ***(If you gain a dependent through birth or legal adoption of a child while you are on leave, you must complete a health and dental enrollment/change form within 62 days of this family status change in order to cover the new dependent under your healthcare plan through the University. If this paperwork is not submitted to your benefits office within 62 days of the birth/adoption, your child will not have coverage after the birth and will not have any coverage if adopted. If you experience a family status change other than the addition of a dependent while you are on leave, you must complete a health and dental enrollment/change form within 31 days of the change.)***

☐ MILITARY EXIGENCY LEAVE – *a qualifying exigency arising out of the fact that your spouse, child, or parent is on active duty or has been called to active duty status in support of a contingency operation as a member of the National Guard or Reserves.*

☐ MILITARY CAREGIVER LEAVE – *the need to care for your spouse, child, parent or next of kin who is a covered service member with a serious injury or illness.*

Have you taken a leave of absence under this Policy during the past twelve months?

❑ Yes ❑ No If yes, when was the last such leave? ____________________

If your spouse works for the University, has your spouse taken a leave of absence under this Policy during the past twelve months?

❑ Yes ❑ No If yes, when was the last such leave? ____________________
❑ Not applicable

If you are requesting NEW CHILD LEAVE, please answer the following questions:

What is the: ❑ anticipated or ❑ actual date of birth or placement? ____________________

If you are requesting a FAMILY MEDICAL LEAVE, EMPLOYEE MEDICAL LEAVE or MILITARY CAREGIVER LEAVE, please answer the following questions:

Have you submitted the necessary medical certification with this form? ❑ Yes ❑ No
Are you requesting full-time leave? ❑ Yes ❑ No

Are you requesting intermittent or reduced leave schedule? ❑ Yes ❑ No

If yes, please answer the following two questions:

Why is it medically necessary for you to have intermittent or reduced leave schedule?

____

____

____

For which dates, times or schedules are you requesting leave?

____

____

____

Do you meet the eligibility requirements for the leave?

❑ Yes ❑ No

By signing below, you are certifying that you have read the Family and Medical Leave and/or Departmental Leave of Absence Policy and you agree to abide by the requirements of the Policy. Failure to abide by these requirements may result in delay or denial of your leave, or it may result in disciplinary action up to and including termination of your employment. By signing, you also affirm that you have been and will be truthful and sincere in your request for a leave of absence.

Employee Signature: ______________________________ Date: ________________