EASTERN MICHIGAN UNIVERSITY™

Request for Leave of Absence (STAFF)

INSTRUCTIONS: Read the vacation, sick time, and leave of absence provisions in the appropriate collective bargaining agreement and/or applicable University policies before completing this form. **To request a leave,** complete sections A, B, C, D and E. **Submit the completed form** to departmental administrator for review and signature at Section F, if not for an FMLA, leave and then submit all Leave documents to 140 McKenny Hall, Human Resources. **Attach any supporting documentation indicated as necessary.** Confirmation notice will be sent after the request for leave has been reviewed. Questions may be directed to 487-3195.

A. EMPLOYEE INFORMATION (Please print clearly in ink.)

Name (last, first, m.i.)		Department Name		Indicate Status: ☐ Part-time ☐ Full-time
Employee ID __ __ __ __ __ __ __ __ __ __	E Class	Date of Hire / /	Work Phone ( )	
Permanent Address (street, city, zip)			Home Phone ( )	
Address While On Leave if Different From Permanent Address			Current Supervisor Name	

B. LEAVE REQUEST INFORMATION (Be thorough here!)

☐ Initial Request ☐ Extension of Leave Request	Dates: From: To:	Last Day Worked:	Indicate Percent of Leave: ☐ Full-time ☐ Part-time %

Type of Leave: **(* Supporting documents are needed prior to approval and should be attached to this form when submitted – If Leave of Absence is for Medical or FMLA, see Fitness for Duty Report.)**
For FMLA, employees complete only sections A-E of this form.

☐ **Family Medical Leave*** ☐ **Military*** ☐ **Medical (includes Maternity)*** ☐ **Child Care** ☐ **Personal** ☐ **Other**

FML Reasons:
- ☐ **Birth/adoption***
- ☐ **Care of sick family***
- ☐ **Employee's own illness***
- ☐ **Intermittent FML***

Signature:______________________________ **Date:** ___________

C. SHORT TERM DISABILITY/WORKERS' COMPENSATION:

I am eligible to receive short-term disability payments: ☐ **Yes** ☐ **No**

If eligible, have you contacted the short-term disability carrier? ☐ **Yes** ☐ **No**
If no, please contact Aetna at 1-866-326-1380.

Is this condition the result of a work-related incident? ☐ **Yes** ☐ **No**

D. BENEFITS (Important! Read carefully.)

If your leave is approved (a) under the Family Medical Leave option or (b) as a regular medical leave, you retain your rights to benefit coverage for up to 12 weeks.

You may be required to use available sick, vacation and/or compensatory time while on leave – check the appropriate collective bargaining agreement or University policy to find out what is applicable.
If not required to use the time, you may elect to use it to maintain an active pay status.

If your leave is other than a Family Medical Leave, or if you are not using available sick, vacation, or compensatory time, ***you will not be covered*** **by University benefits** ***unless you elect to continue them at your own expense*****.** Indicate below what you are choosing to do.

D. BENEFITS (cont'd)

1. ☐ **Continue my insurances.** I understand that the Benefits Office will notify me of the rates and payment schedules to maintain benefits.

2. ☐ **Discontinue my insurances.** Upon my return to work, I understand *I must re-enroll within 30 days of my return to work, and that failure to do so will result in the loss of my benefits.*

(NOTE: Failure to select one of the options above will also result in immediate cancellation of insurance in accordance with the collective bargaining agreements and University policies.)

E. PAID/UNPAID STATUS (Both employee and department information needed here)

Review with your department all available time you have accrued to answer this section. Also review all applicable sections of your collective bargaining agreement or work rules to understand required usage before answering the following:

Check all that apply:

☐ **I do want to use my available sick time if applicable.**
Indicate amount available ________to be used _________. Pay ending date _____________________

☐ **I do want to use my available vacation time.**
Indicate amount available ________to be used _________. Pay ending date _____________________

☐ **I do want to use my available compensatory time.**
Indicate amount available ________to be used _________. Pay ending date_____________________

☐ **I do want to use my available sick bank.**
Indicate amount available ________to be used _________. Pay ending date_____________________

F. DEPARTMENT INFORMATION (Department signatory)

The above information has been reviewed and is accurate to the best of my knowledge.

For FMLA, department heads/supervisors do not sign.

Signature of Department Head ____________________________________ **Date** _______________

We ☐ recommend approval ☐ cannot recommend approval (reason):

The department will: ☐ hold the position (NORMALLY required if FML)
☐ post the vacancy after consulting with your Divisional Human Resources Consultant

G. HUMAN RESOURCES

This leave of absence request: ☐ has been approved
☐ has been denied

Reason: ____
____

____ ______________________________
Human Resources Representative **Date**

Please note:

To extend this leave: **Appropriate documentation must be submitted *in advance* of the approved end date above (see Medical Certification of Health Care Provider Addendum Form). Fax # 734 487-4389**

To return to work: **Notify Human Resources two weeks *prior to end of leave* to confirm return to work date.**

Questions may be directed to:
Benefits Office (734) 487-3195 Employment Services (734) 487-3430 Payroll Office (734) 487-2393