THE UNIVERSITY OF CHICAGO | Human Resources

Effective: 11/2018

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

LEAVE REQUEST FORM (Use for STD, Parental Leave, and MLOA)
HEALTHCARE PROVIDER'S STATEMENT

1) Have the "Healthcare Provider's Statement" completed and submitted directly to HR Leave Administration via email at leaveadministration@uchicago.edu or fax to 773-702-6098.
2) Healthcare Providers: Please note "unknown and undetermined" are not acceptable as answers. Specific dates must be provided where indicated.

IF REQUESTING SHORT-TERM DISABILITY OR PARENTAL LEAVE CONCURRENT WITH FMLA YOUR HEALTH CARE PROVIDER ONLY NEEDS TO COMPLETE THE APPLICABLE FMLA HEALTHCARE PROVIDER STATEMENT

Healthcare Provider's Statement

Patient's Name:

Diagnosis and current condition(s):

ICD-10 Diagnostic Code(s):

Date condition commenced:

Probable duration of condition:

Is the employee unable to perform any of his/her job functions due to the condition? ☐ Yes ☐ No

As of what date do you consider the employee disabled from performing any job functions?

Is the medical condition pregnancy? ☐ Yes ☐ No If so, expected delivery date: Expected delivery type: ☐ Vaginal ☐ C-section

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave:

Date employee may return to restricted duty: For what period (# of days):

State restrictions:

Date employee may return to regular duty: ☐ Estimate ☐ Actual

Healthcare Provider's Information

Healthcare provider's name: Type of practice/Medical specialty:

Provider's business address:

Telephone: Fax:

Signature: