LEAVE OF ABSENCE REQUEST FORM

University Health

Name: _____ Employee ID#: _____ Shift: _____

Department: _____ Supervisor: _____

Home Address: _____ Home Phone: _____

City/State/Zip: _____ Alternate Phone: _____

Please read Leave of Absence Guide for policy details on pages 5-13, and then complete the following.

Reason for Leave of Absence: (Please select one)

☐ **Leave of Absence under FMLA** ☐ **Continuous** ☐ **Intermittent**
(Submit the certification of health care provider form within 15 days.)
☐ Self ☐ Spouse ☐ Child - Age:_____ ☐ Employee's Parent ☐ Maternity/Paternity
☐ Worker's Compensation
*Is this person a military service member? ☐ Yes ☐ No

☐ **Medical Leave** (Submit the certification of health care provider form within 15 days.)
(Medical leave is continuous and only available for a qualifying employee's own serious health condition.)

☐ **Qualifying Exigency Leave** ☐ **Continuous** ☐ **Intermittent**
(Attach copy of military orders)
☐ Self ☐ Spouse ☐ Child ☐ Employee's Parent

☐ **Military Leave** ☐ **Continuous** ☐ **Intermittent** (Also for Military weekend drills)
(Attach copy of military orders)
Do you wish to discontinue your benefits while on Military leave? ☐ Yes ☐ No

Requested Dates for Leave of Absence _____ to _____

Extension to Current Leave of Absence: (Complete only if extension to current leave is needed)

Dates of Current Leave of Absence: _____ to _____

Request Dates for Extension: _____ to _____

University Health System reserves the right to investigate the reason given for this leave of absence before and after granting the leave. If the reason has been misrepresented, you are subject to immediate discharge without notice. If you print this form, then please e-mail to UHS.Benefits@uhs-sa.com after completion.

_____ _____

Employee Signature Date