UCF Human Resources

# *MEDICAL LEAVE REQUEST FORM*

**Please Print, Type, or Write Legibly**

**Check one:** **New Leave of Absence:** ☐ **Revision of original request (superseding):** ☐ **Extension of Leave:** ☐

**Department Name:** _____ **College/Division:** _____

**Employee ID #:**_____ **Position Title:** _____ **Check one: USPS:** ☐ **A&P:** ☐ **Faculty:** ☐ **OPS:** ☐

**Employee's Name:** _____
**Last name** **First name** **Middle Initial**

**Home Mailing Address:** _____
**Street Address/P.O. Box** **City** **State** **Zip**

**Home Email Address:** _____ **Campus Email Address:** _____

**Campus Phone #:** _____ **Home Phone #:** _____ **Cell Phone #:**_____

**Type of Leave:** **Medical –Employee*:** ☐ **Medical- Family *:** ☐

**Reason for Leave:** **Employee's own serious health condition:** ☐ **To care for the following family member with a serious health condition:** ☐

**Child:** ☐ **Spouse:** ☐ **Parent:** ☐ **Brother:** ☐ **Sister:** ☐

**Name of Relative:** _____ **Relationship:** _____

**Injured Service Member:** ☐ **Military Exigency:** ☐ **Reason:**_____

***A UCF Certification of Health Care Provider Form for Self or a Family Member must be submitted with this request form.**

**Last Day of Work:** _____ **Start Date:** _____ **End Date:** _____

**I anticipate returning to my normal work schedule and duties on: Date:** _____ **Time:** _____

**My leave will be: A Full Unpaid Leave:** ☐ **A Paid Leave:** ☐ **A Combination of Paid and Unpaid Leave:** ☐ **An Intermittent Leave:** ☐

**A Reduced Work Schedule Leave (A proposed work schedule must be attached):** ☐

**While not working I will use accrued:** **Sick:** ☐ **Annual:** ☐ **Compensatory:** ☐ **Leave Without Pay (LWO):** ☐

**I am a sick leave pool member and I may be requesting sick leave pool hours: Yes:** ☐ **No:** ☐

***I understand** and accept a leave of absence as stated on this page. I further acknowledge that I have read the "Employee and Department Responsibilities for Completion" page accompanying this form and **I understand** all of my leave responsibilities and the information provided therein:*

**Employee Signature:** _____ **Date:** _____

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## For Use By Department and Human Resources

**Department (Supervisor) must complete (Please type or print legibly):**

**Payroll Processor:** _____**email:**_____

**EPaf Processor:**_____**email:**_____

**HR Liaison:**_____**email:**_____

**Approved**

**Yes:** ☐ **No:** ☐ ***Signature Chair/Supervisor:*** _____ Date: _____

Print Full Name: _____ Campus Extension:_____

Email Address:_____

**Yes:** ☐ **No:** ☐ ***Signature Dean/Director:*** _____ Date: _____

Print Full Name: _____ Campus Extension: _____

Email Address: _____

Comments:_____

_____

**For HR Use Only** ***The Human Resources Director has Final Approval for all medical leaves of absence.***

**This request for leave of absence is approved:** ***YES:*** ☐ ***NO:*** ☐ **Employee is on paid leave:** ☐

**This leave counts toward the employee's FMLA entitlement:** ***YES:*** ☐ ***NO:*** ☐ **Employee is on unpaid leave:** ☐

**During this leave the employee will use approximately _____ weeks of their twelve (12) week FMLA entitlement and will have _____ weeks of entitlement remaining for use in fiscal year _____; Intermittent leave is not scheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA leave entitlement. Your department will track your FMLA leave usage and you may request this information once in a 30-day period.**

Human Resources Director: By: _____ Date: _____

Comments:_____

_____

# Employee and Department Responsibilities and Instructions for Completion of Medical Leave Request Form

1. Falsification of this request, or any documentation provided to support this request, is cause for immediate dismissal.

2. I understand that no later than two (2) weeks before my scheduled date to return to work, or by the date stated in my leave letter, I **must** complete an Intent to Return to Work and Medical Release Form. I understand that my doctor must complete the Medical Release Section if I am out due to my own illness. If I am not returning on the date stated on my request form, I must request an extension of this leave of absence, or I must submit my written resignation. I understand that if I do not follow the university's leave procedure, I am subject to applicable disciplinary action. Any issues in obtaining forms or documentation by the date provided in my leave approval letter must be reported to my supervisor and/or the HR Leave Coordinator prior to the deadline for the submission of documentation in order for me to be in compliance with the university's leave procedure**. I acknowledge that I am responsible for payment of my benefits premiums. If, for any reason, the premiums are not deducted from my paycheck it is my responsibility to immediately contact the HR Benefits Section at 407-823-2771 and make arrangements to pay for my premiums, otherwise they may be suspended.**

3. **This request for leave must have Departmental Approval/Signature by the Chair and Dean for Faculty or by the Supervisor and Director/Dean for USPS and A&P. I will submit the request to my supervisor.**

4. An employee is on a "paid" leave of absence for Payroll and Records purposes if he or she is using accrued leave to remain in full pay status, or if the employee is using a combination of accrued leave and leave without pay. An employee is on an "unpaid" leave when they request the leave to be unpaid or they exhaust all of their accrued leave.

5. If this request for a medical leave of absence is recommended for approval as a "paid" leave, and the employee later exhausts all of his or her accrued leave an ePAF must be completed by the department and forwarded to Human Resources-Records and the HR Leave Coordinator must be notified separately. At the bottom of this form the HR Leave Coordinator has checked the current pay status the employee will be in on this leave. The leave request form is a source document and automatically places the employee on a leave of absence for payroll and records purposes; however, when an employee returns to work from a leave of absence the department must process an ePAF returning the employee back to active pay status.

6. If this is the first time you are requesting a leave of absence for this illness (self or family), check the new leave of absence box; if you have already submitted a request for this leave, but the dates for the leave of absence or other information has changed since the original request was submitted, check revision of original request; if you are requesting an extension of a previously approved leave of absence that is ending, check the extension of leave box.

7. **Please do not leave any sections blank.** Enter your department name, College/Division, Employee Identification number, job title, and check the appropriate pay plan to indicate whether you are a USPS, A&P, Faculty, or OPS employee. Enter your last name, first name, and middle initial. Enter your home mailing address, home email address and campus email address. Enter your campus phone number, home phone and cell phone numbers (including area codes).

8. Check the type of leave you are requesting: medical for yourself or medical for a family member. Please note that medical documentation must be provided with each request for a leave of absence. **A UCF Certification of Health Care Provider Form must be attached, or sent directly to your HR Leave Coordinator, for each request for medical leave except for leave which is due to a Military Exigency. For Military Exigency please provide document to support the request.**

9. State your last day of work and the date your leave will begin and end, plus the date and time you will return to work.

10. Check a box indicating if you are requesting a *full unpaid* leave, a *paid* leave, and/or an *intermittent* leave, or a *reduced work schedule* leave. During a full unpaid leave an employee is not working and not receiving pay. While on a paid leave an employee is not working and is using either all accrued leave or a combination of accrued leave with leave without pay. Intermittent Leave is when an employee will take leave for irregular periods of time due to diagnosis on the Certification of Health Care Provider Form. A reduced work schedule leave is when an employee is requesting a change in their normal work hours, from full-time to less-than-full-time, as recommended by their physician. When requesting a reduced work schedule the employee must attach a proposed work schedule**. To work from home a UCF Telecommuting Agreement is required for A&P and USPS employees.**

11. If any part of your leave will be paid, check the box that applies to the type of accrued leave you have and will use. **Please note that you are responsible for your benefits premium payments and if you do not have sufficient accrued leave, or if you run out of accrued leave, you must contact the HR Benefits Section at 407-823-2771 to make arrangements to pay for your benefits premiums or your benefits will be suspended and unusable until all back payment is received and processed.**

12. Please indicate whether you have requested or will request hours from the sick leave pool. It is your responsibility to forward the request for sick leave pool hours and any necessary documentation to Human Resources if you are USPS, or to Academic Affairs if you are Faculty or A&P.

13. Faculty employees should submit the Medical Leave Request Form and Certification of Health Care Provider Form to the department chair, who will approve or disapprove the request and forward it to the dean for approval or disapproval. If you prefer that your department does not see your medical information you may send it directly to your HR Leave Coordinator.

14. USPS and A&P employees should submit the Medical Leave Request Form and Certification of Health Care Provider Form to his or her immediate supervisor, who will approve or disapprove the request and forward it to the department head, director and/or vice president for approval or disapproval. If you prefer that your department does not see your medical information you may send it directly to your HR Leave Coordinator.

15. The final approval or denial authority for **medical leaves of absence** has been delegated to the Director of Human Resources.

16. **All Medical Leave Request Forms must be signed and forwarded by the department to Human Resources within forty-eight (48 hours) of receipt for final approval.**

17. **Please note that the Intent to Return to Work and Medical Release Form is required for all employees who are returning to work after a medical leave for their own illness (this includes employees who will be working from home) and the department must process an ePAF when an employee returns to work from a leave of absence to return the employee back to active pay status. An employee on an intermittent leave does not require a medical release to return to their normal work hours, but must complete the Intent to Return to Work Form.**

You will receive notification of approval or denial of the requested medical leave of absence via email (if address is provided) and regular mail. Questions regarding this form should be directed to the Leave Administration Section at 407-823-2771, or you may email questions to loaandworkcomp@mail.ucf.edu.