Medical Leave of Absence Request Form (for employee or family member)

Complete Part I, sign and return to Human Resources. Human Resources will facilitate the approval and notification process. Requests for leaves of absence should be made at least 30 days in advance whenever possible. Staff and Faculty members should read the appropriate paid/unpaid leaves of absence policies in the HR Policy Manual (section 10) prior to completing the Leave of Absence Request Form.

Part I - To be completed by Employee

Employee Name (please print): ______________________________ Hire Date: _______ Home Phone:__________

Home Address: ____

City, State, Zip Code: ____

☐ Faculty ☐ Staff Title: ____________________________________ Department: ___________________

Supervisor: ___________________

Type of Leave (check all applicable):

- ☐ Maternity Leave (for employees with less than 12 months of service **or** in addition to FMLA if eligible)
- ☐ Medical Leave for Employee
- ☐ Family Medical Leave (FMLA) for Employee (concurrent with Medical Leave)
- ☐ Family Medical Leave for Spouse, Dependent Child or Parent
- ☐ Short-Term Disability (please complete reverse side of form)

Start of leave (first day absent from work): ____

End of leave (last day absent from work): ____

Regular Hours worked/week: ___________ ☐ Full-Time ☐ Part-Time

Intermittent Leave Request: ☐ Yes ☐ No If Yes, please attach proposed schedule. Intermittent leave must be approved by Department Head and Human Resources.

For all leave and short-term disability, a completed Certification of Health Care Provider form must be turned in within 15 days of receipt of this form, except for FMLA leave to care for a child after birth or adoption. If this is intermittent leave or a reduced work schedule, please attach a description of the schedule of days/hours that will be considered leave time.

Accrued Leave Benefits

An employee must exhaust all accumulated sick leave at the onset of the leave period for their own serious health condition. An employee may use sick leave to continue paid status for other family members or vacation leave following exhaustion of sick leave.

Do you wish to use vacation leave for any unpaid leave? ☐ Yes ☐ No

If yes, how many hours do you want to use? ____________ Hours ☐ All Available

You may qualify for sick leave donations if you have exhausted your sick leave account and all but five days of vacation because of a serious personal illness or injury. These may be used during the 30-day waiting period before short-term disability begins. Ask Human Resources if you think you may qualify.

Health Benefits

If medical leave and/or FMLA leave is requested to care for a child after birth or adoption, do you plan to add the child to your SU medical insurance? ☐ Yes ☐ No If yes, you must complete a Status Change Request Form within 60 days of the child's birth or adoption.

If the proposed medical leave includes any full month of unpaid leave, how will you pay for your portion of the benefit costs (typically costs beyond what Benefit Dollars provide) ☐ By Personal Check ☐ Payroll Deduction (deducted prior to leave)

Please sign and return this form to Human Resources with any accompanying documentation (physician certification where requested or military authority). Please note that a leave is not approved until all approval/notification signatures have been obtained. You will be notified when the process is complete.

Employee Signature: ____Date: __________________

Department Head/Dean: ____Date: __________________

Printed Name of Department Head/Dean:____________________________________

Part II - To be completed by Employee (if applicable)

Short-Term Disability
Application For Benefits

Short-Term Disability is a benefit offered by the University to preserve partial income of those benefits eligible employees who are unable to work because of a medical condition. An employee who has completed twelve (12) continuous months of active employment with the University prior to the onset of the disability is eligible for this benefit. An employee must be disabled for thirty (30) consecutive calendar days to apply for this benefit. This plan takes effect on the 31st calendar day of disability. Total sick leave and Short-Term Disability payments will cease at the end of 180 days from the date of the onset of disability.

Is your condition related to your job? ☐ No ☐ Yes If yes, explain: ____________________________________
If yes, have you filed a claim for Worker's Compensation? ☐ Yes ☐ No If Yes, Date Applied: ___/___/___
Do you have a pending lawsuit for this injury? ☐ Yes ☐ No

IF YOUR CLAIM IS FOR PREGNANCY/CHILDBIRTH, PLEASE PROVIDE THE FOLLOWING:

Expected or Actual Delivery Date: ___/___/___ Type of Delivery: ☐ Vaginal ☐ C-Section- Date Scheduled: ___/___/___
Last day worked: ___/___/___ Expected or actual return to work date: ___/___/___

IF AN ILLNESS, what is the nature of your condition? ____
____When did you first notice symptoms? ___/___/___

IF AN INJURY, date of injury: ___/___/___ Where did the injury occur? ☐ Home ☐ Work ☐ Other

How did the injury occur? ____
____

Date first treated for this condition by a physician: ___/___/___ Last day worked: ___/___/___
Have you been treated for this or a similar condition in the past? ☐ Yes ☐ No If yes, when? ___/___/___
Has your doctor advised you to restrict your activities in any way? ☐ Yes ☐ No Explain: ____________________________
____

Please provide the following information of your doctor.

Name and Specialty	Full Address	Telephone Number	Treated From	To
		( )	___/___/___	___/___/___

Is this the only doctor you are seeing for treatment and care related to your disability? ☐ Yes ☐ No If No, attach a list of all other doctors' names, addresses, telephone numbers and specialties.

I authorize my caregivers to provide the Seattle University Human Resource department with information concerning medical care, advice, treatment or supplies provided to the claimant, and any employment-related information regarding the claimant. This information will be used for the purpose of evaluating and administering the claim for benefits. A verbal interview is also authorized. A copy of this authorization shall have the same authority as the original.

I understand that the duration of this authorization is for the term of coverage concerning my application for short-term disability benefits. I also understand that I have a right to receive a copy of this authorization upon request.

I hereby certify that the answers I have provided on this form are full, complete and true.

X____ ___/___/___
Signature Date