



## MEDICAL LEAVE REQUEST FORM

**NOTE:** For use only with requests for Family & Medical Leave, Family Illness Leave, and/or leave without pay due to medical reasons (including major disability, and parental leave). Not for use with routine sick leave.

<b>Date of Request:</b>	<input type="checkbox"/> New Request	<input type="checkbox"/> Supplement to Previous Request
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### I. EMPLOYEE DATA

<b>Employee Name:</b>			
<b>Dept Name:</b>		<b>Work Phone:</b>	
<b>Banner ID #:</b>		<b>Home Phone:</b>	
<b>E-Mail Address:</b> (Approval sent via e-mail)		<b>Cell Phone:</b>	
<b>Appointment:</b>	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	<input type="checkbox"/> SHRA <input type="checkbox"/> EHRA	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time – Hrs/Wk:
<b>Supervisor Name:</b>			<b>Spvsr Phone:</b>

### II. MEDICAL CONDITION INFORMATION

<b>Leave Selection(s)</b> (check all that apply): <input type="checkbox"/> Family & Medical Leave <input type="checkbox"/> Family Illness Leave <input type="checkbox"/> Leave Without Pay <input type="checkbox"/> Military Caregiver/Qualified Exigency	<b>Reason(s) for Requiring Leave:</b> <input type="checkbox"/> Serious Health Condition of the Employee <input type="checkbox"/> Serious Health Condition of a: <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Covered Military Member <input type="checkbox"/> Qualified Exigency for National Guard or Reserves <input type="checkbox"/> New Child: <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Foster Care Placement		
Submit Applicable Medical Certification Form to the Office of Human Resources: WH-380-E for Serious Health Condition of Employee WH-380-F for Serious Health Condition of Family Member			
<b>Attach Medical Certification Form(s) if required:</b>	Second Medical Certification Required? <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of Exam:	
	Third Medical Certification Required? <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of Exam:	

### III. MEDICAL LEAVE REQUEST

<b>If requesting a medical leave of absence:</b>	Start Date:		End Date:	
<b>If requesting a reduced work schedule:</b>	Start Date:		End Date:	
	Hrs/Week:		Work Schedule:	
<b>If requesting an intermittent work schedule:</b>	Start Date:		End Date:	
Expected Frequency of Absences:				
Expected Duration of Absences:				

### IV. EMPLOYEE SIGNATURE

Do you want to exhaust leave?    YES    NO   If uncertain, please contact the Leave Specialist at 910.521.6767 to review leave options. **For paid leave, faculty must also request Faculty Serious Illness & Disability Leave.**

Employee's Signature	Date
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Supervisor's Acknowledgment of Request for Leave

Supervisor's Signature:	Date
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**V. ROUTING OF DOCUMENTATION**

Submit this Leave Request Form along with Medical Certification Form(s) and any supporting documentation to:  
Attention: Benefits Consultant, Office of Human Resources (OHR), Lumbee Hall Suite 347, PO Box 1510, Pembroke, NC 28372  
Fax: 910.521.6553 / Tel: 910.521.6279

**FACULTY:**

In addition to submission of this form with Medical Certification to the OHR, you must also submit the Serious Illness & Disability Leave for Faculty Request Form to your Department Chair.

**VI. FOR OFFICE USE ONLY**

<b>Family &amp; Medical Leave:</b>	<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	<input type="checkbox"/> N/A	<b>Notes/Comments</b>
<b>*Family Illness Leave:</b>	<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	<input type="checkbox"/> N/A	
<b>[Redacted Signature Line]</b>				
<b>Signature – Human Resources:</b>			<b>Review Date:</b>	

\*Note: If eligible for FMLA, the employee must exhaust FMLA prior to using the Family Illness Leave option.