



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:

Worker's Compensation - Employee: Name of Relative: _____ Relationship: _____
Child: Spouse: Parent: Brother: Sister:

Injured Service Member: Military Exigency:

**A UCF Certificate 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 "Responsibilities for Employees and Departments and Instructions for Completion" page accompanying this form and **I understand** all of my leave responsibilities and the information provided therein:

Employee Signature: _____ Date: _____

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: _____ Email Address: _____
Campus Extension: _____ Fax Number: _____

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

Print Full Name: _____ Email Address: _____
Campus Extension: _____ Fax Number: _____

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, the initial violation may result in a written reprimand; a second occurrence will result in suspension; and a third occurrence will result in Discharge/Termination of my position.** 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 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 my Request to my supervisor.**
4. An employee is on a "paid" leave of absence for Payroll and Records purposes if s/he 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/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 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. (a copy of your leave approval letter will be emailed to the email address you provide). Enter your department name, 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. For the definition of a serious health condition, please refer to page three of the UCF Certificate of Health Care Provider Form. Please note that medical documentation must be provided with each request for a leave of absence. ***A UCF Certificate of Health Care Provider Form must be attached, or sent directly to your HR Leave Coordinator, for each request for medical leave for self, or for a family member, or for leave which is due to a UCF work-related illness or injury (workers' compensation – may submit a DWC-25 Medical Treatment Report in lieu of a Certificate of Health Care Provider Form).***
9. State your last day of work and the date your leave will begin and end, plus the date you will return to work.
10. Check the appropriate box 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 in separate periods of time due to diagnosis on the Certification of Health Care Provider Form, i.e. such as physical therapy. 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 HR Benefits Section 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. Please do not attach the sick leave pool request to the Request for Medical or Parental Leave Form.
13. Faculty employees must submit the Request for Medical Leave Form and Certificate of Health Care Provider Form to the department chair, who will approve/disapprove the request and forward it to the dean for approval/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 must submit the Request for Medical Leave Form and Certificate of Health Care Provider Form to his/her immediate supervisor, who will approve/disapprove the request and forward it to the department head, director and/or vice president for approval/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/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 from the department to Human Resources within forty-eight (48 hours) of receipt for final approval.***
17. ***Please note that an Intent to Return to work with a medical release is required for all employees who are returning to work after a medical leave (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 in order to return the employee back to active pay status. An employee on an intermittent work schedule does not require a medical release to return to their normal work hours, but must complete the Intent to Return to Work Form. The Intent/Release forms should not be attached to ePAF's - a copy must be sent by the department to the employee's leave coordinator.***

You will receive notification of approval/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 your Human Resource Leave Coordinator for last names A-L, contact 407-823-3730; for M-Z, contact 407-823-0540 or you may email questions to loaandworkcomp@mail.ucf.edu.