Application for Family and Medical Leave/Disability Leave of Absence

Name:_____ PRN:_____

Department:_____ Position:_____

Supervisor:_____

Date of Hire:_____

Leave Start Date:_____ **Expected Return Date**:_____

Reason for Leave: (check one)

☐ Birth, adoption, or foster care placement of a child

Name:_____ Date of Birth:_____

☐ Employee's own Serious Health Condition

☐ Serious Health Condition of

- ○ Parent Name:_____
- ○ Child Name:_____
- ○ Spouse Name:_____
- ○ Parent In-Law Name:_____

☐ To care for an ill or injured service member

Name:_____

☐ Qualifying exigency leave for families or members of the National Guard or Reserve

Will leave be on an intermittent or reduced leave schedule? (explain reasoning and proposed schedule)

Leave time Earned Hours To Be Used During Leave (refer to the Personnel Handbook or Human Resources to determine what types of time are available for the type of leave requested)

___Vacation ___Personal ___Holidays ___Floating Holidays ___Sick ___Advanced Sick ___Parental/Child Rearing

I recognize that if I take any paid vacation prior to my having earned it, the vacation time shall be treated as an advance from UNE to me. If my employment from UNE should end prior to my fully earning any vacation time advanced to me, I authorize UNE to deduct, from my paycheck(s) any monies owed on unearned vacation time. I agree that this electronic transmission of my authorization shall have the same effect as though I signed this document.

I understand that if my income during a period of Family medical leave or other leave is not sufficient to cover my portion of the costs of insurance coverage, I am expected to pay those costs on a monthly basis. In the event that those costs are not fully paid, I understand that these are my obligations, that the University's payment of them is in the nature of a loan, and I authorize reimbursement from payroll deduction for the balance owed. In the event of employment termination with insufficient funds to pay through payroll deduction, I agree to pay my obligations to the University immediately.

UNE UNIVERSITY OF NEW ENGLAND

INNOVATION FOR A HEALTHIER PLANET

Application for Family and Medical Leave/Disability Leave of Absence

A leave request based on the serious Health Condition of the employee or employee's qualified family member will require completion of a **medical certification form** which will be provided by Human Resources (Cat Martins, Benefits Coordinator).

Health Care Provider Information

Name:_____ Telephone Number:_____

Address:_____

I hereby authorize the Health Care Provider to release information and medical records as necessary to verify the medical facts of the Serious Health Condition of myself or that of my son or daughter with regard to the need for this Family and Medical Leave/Disability, and to do so without liability for such release of information, I understand that a separate authorization signed by the parent, parent-in-law, or spouse is required for the release of the medical facts concerning their Serious Health Condition. I understand that failure to return the required medical certification in a timely manner may delay my leave or even result in the leave being ineligible under FMLA/Disability.

I understand that if I return to work upon expiration of my Federal/State leave, I will be reinstated to the same or equivalent position in accordance with Federal and State law. If I wish to return to work prior to the expiration of my leave, I will notify Human Resources at least two (2) business days prior to my desired return date and will provide a doctor's note allowing my return.

I understand that failure to return to work when this leave period expires for any reason other than those protected by FMLA laws/UNE's Disability Policy, may be considered a resignation unless an extension has been agreed upon and approved in writing by the employee, supervisor, and Executive Director of Human Resources.

I understand University of New England will continue to maintain my **health care coverage** while I am on FMLA/Disability, provided I continue to contribute the required employee portion of the premium payment. I hereby agree to submit my portion of my health care coverage premium on the following schedule:

◯ Weekly ◯ Semi Monthly ◯ Monthly ◯ In Advance

***By signing this form, I understand that while on an approved leave I am not required to work. Should I wish to return to work (intermittently on campus or from home) while on leave for my own medical condition, I will obtain a "Fit for Duty" certification from my doctor and an authorization from the Executive Director of Human Resources prior to performing any job duties.**

Employee Signature:_____ Date:_____

Supervisor Signature:_____ Date: _____

Senior Administrator Signature:_____ Date:_____

Human Resources Approval:_____ Date:_____

UNE UNIVERSITY OF NEW ENGLAND

INNOVATION FOR A HEALTHIER PLANET