

STATE OF COLORADO  
**UNIVERSITY OF NORTHERN COLORADO**  
**Exempt/Administrator Leave-Absence Request and Authorization**

Any medical information is confidential and must be kept in separate files with limited access.

**Name:** \_\_\_\_\_ **Department & Division:** \_\_\_\_\_  
**Emergency contact:** \_\_\_\_\_  
**ID NUMBER :** \_\_\_\_\_ **Name:** \_\_\_\_\_

**I understand that leave must be requested and approved in advance, where foreseeable. I understand that I must provide sufficient information so the proper type of leave can be determined. I understand that I am responsible for keeping my supervisor informed of any change in this request.** If a medical condition is highly sensitive, please contact the Human Resources Office as soon as possible for guidance on other benefits available.

I request approval for \_\_\_\_\_ total hours as listed below. Is the absence due to a work-related illness or injury?  No  Yes

**Record dates and number of hours in the blanks before each applicable reason. (More information may be required.)**

From	Actual Dates To	#Hrs.	
_____	_____	_____	Vacation (not related to care/treatment of a medical condition or bonding with a new child)
_____	_____	_____	
_____	_____	_____	Medical: If not self, relationship _____
_____	_____	_____	Routine eye, medical, dental exam.
_____	_____	_____	Common illness/injury (no prescribed treatment, e.g. cold, flu)
_____	_____	_____	Other Medical (inpatient or continuing treatment, e.g., surgery, childbirth). Explain reason.
_____	_____	_____	Other: Explain reason: _____

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

**Check here if form Amended** \_\_\_\_\_

**To Be Completed By Supervisor: Indicate type of leave of absence approved and the number of hours by type:**

Type of Leave or Absence Approved: (indicate # of hours by type)

_____ Annual	_____ FML-family sick	_____ Jury	_____ Military
_____ Sick	_____ FML-LWOP	_____ Administrative Leave	_____ Military Train
_____ Family Sick	_____ FML-STD	_____ Adm – school	_____ Other (Specify)
_____ STD	_____ FML-holiday	_____ Adm. – volunteer	_____
_____ FML-annual	_____ Funeral	_____ Voluntary Furlough	_____
_____ FML-sick	_____ Alt. Holiday	_____ LWOP	_____ Comp. Time (If eligible)

**To Be Completed By Human Resources:**

A Medical certification \_\_\_ is required \_\_\_ is not required. (Required for more than 3 full consecutive working days.)

A Fitness-to-Return certification \_\_\_ will be \_\_\_ will not be required before returning to work on a regular basis. (Required for an absence of more than 30 days.)

For purposes of **family medical leave designation**, I have determined, (as the appointing authority or designee,) the following.

- The employee is not eligible for family/medical leave until \_\_\_\_\_ (date).
- The employee is eligible but has already used the hours allowed in this fiscal year.
- The event does not qualify for family/medical leave.
- The employee is eligible for family/medical leave AND the event does, or could, qualify for family/medical leave. (The State of Colorado Employer Individual Notice for Family and Medical Leave form must be completed and given to the employee within 2 business days of this request, absent extenuating circumstances.)
- Continuation of a previously designated event (continuing treatment or recovery).

Approved by \_\_\_\_\_ Date \_\_\_\_\_

Director of Human Resources/Designee