UNIVERSITY of NORTHERN COLORADO

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Exempt Administrator Leave-Absence Request & Authorization

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

Name _____ ID Number _____ Work # _____

Department & Division _____

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, contact Human Resource Services 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.)

Actual Dates and Times		*# of Hours*	
From	***To***		
_____	_____	_____	***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 & relationship, e.g., bonding, funeral, jury, adoption, consulting)*

Explain Reason: _____

Employee Signature _____ Date _____ **Check Here if Form Amended** ☐

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

___ *Annual*	___ *FML –annual*
___ *Sick*	___ *FML - sick*
___ *Family Sick*	___ *FML – family sick*
___ *STD*	___ *FML – STD*
___ *Military*	___ *FML – Military Family*
___ *Bereavement*	___ *FML – Military Caregiver*
___ *Alt. Holiday*	___ *FML – Holiday*
___ *Unpaid*	___ *FML – Unpaid*
___ *Administrative*	___*Admin-school*
___ *Jury*	___ *Admin – volunteer*
___ *LWOP*	___ *Voluntary Furlough*
___ *Compensatory Time (if eligible)*	
___ *Other Specify* _____	

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)

Supervisor Signature: _____ *Date* _____

To be completed by Human Resource Services:

For purposes of family medical leave designation, I have determined the following:

☐ *Employee is not eligible for family – medical leave until* _____ *(date)*

☐ *Employee is eligible, but has already used the hours allowed in this fiscal year.*

☐ *Event does not qualify for family-medical leave*

☐ *Employee is eligible for family-medical leave AND the event does, or could, qualify for this leave.*

☐ *Continuation of a previously designated event (continuing treatment or recovery)*

_____ _____

Director of Human Resource Services/Designee *Date*