UNIVERSITY OF NORTHERN COLORADO
Faculty Leave/Absence Request and Authorization

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

Name _____ **Department & Division** _____

ID Number _____ **Work #** _____

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.)

Actual Dates From	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 _____

Dept. Chair/Dean 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)

_____	Sick	_____	FML-family sick	_____	Jury	_____	Other (Specifiy)
_____	Family Sick	_____	FML-LWOP	_____	LWOP	_____	
_____	LTD	_____	FML-LTD	_____	Military	_____	
_____	FML-sick	_____	Funeral	_____	Military Training		

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

Rev 2/18/2000