# MEDICAL LEAVE REQUEST FORM

**NOTE:** For use only with requests for Family & Medical Leave, Family Illness Leave, and/or leave without pay due to medical reasons (including major disability, and parental leave). Not for use with routine sick leave. Additional information can be found at https://ncoshr.s3.amazonaws.com/s3fs-public/documents/files/Family%20and%20Medical%20Leave_0.pdf.

| **Date of Request:** | ☐ New Request | ☐ Supplement to Previous Request |
|---|---|---|

## I. EMPLOYEE DATA

| | | | |
|---|---|---|---|
| **Employee Name:** | | | |
| **Dept Name:** | | **Work Phone:** | |
| **Banner ID #:** | | **Home Phone:** | |
| **Home Address:** | | **Cell Phone:** | |
| **Appointment:** | ☐ Permanent ☐ SHRA<br>☐ Temporary ☐ EHRA | ☐ Full-Time<br>☐ Part-Time – Hrs/Wk: | |
| **Supervisor Name:** | | **Spvsr Phone:** | |

## II. MEDICAL CONDITION INFORMATION

| **Leave Selection(s)** (check all that apply)**:** | |
|---|---|
| ☐ Family & Medical Leave<br>☐ Family Illness Leave<br>☐ Leave Without Pay | ☐ Military Caregiver/Qualified Exigency |
| Submit Applicable Medical Certification Form to the Office of Human Resources:<br>WH-380-E for Serious Health Condition of Employee<br>WH-380-F for Serious Health Condition of Family Member | |

| **Reason(s) for Requiring Leave:** |
|---|
| ☐ Serious Health Condition of the Employee |
| ☐ Serious Health Condition of a: |
| ☐ Parent ☐ Child ☐ Spouse ☐ Covered Military Member |
| ☐ Qualified Exigency for National Guard or Reserves |
| ☐ New Child: |
| ☐ Birth ☐ Adoption ☐ Foster Care Placement |

| | | | | | |
|---|---|---|---|---|---|
| **Attach Medical Certification Form(s) if required:** | Second Medical Certification Required? | ☐ YES | ☐NO | Date of Exam: | |
| | Third Medical Certification Required? | ☐ YES | ☐NO | Date of Exam: | |

## III. MEDICAL LEAVE REQUEST

| | | | | |
|---|---|---|---|---|
| **If requesting a medical leave of absence:** | Start Date: | | End Date: | |
| **If requesting a reduced work schedule:** | Start Date: | | End Date: | |
| | Hrs/Week: | | Work Schedule: | |
| **If requesting an intermittent work schedule:** | Start Date: | | End Date: | |
| Expected Frequency of Absences: | | | | |
| Expected Duration of Absences: | | | | |

## IV. EMPLOYEE SIGNATURE

Do you want to exhaust leave? ☐ YES ☐ NO If uncertain, please contact the Leave Specialist at 910.521.6767 to review leave options. **For paid leave, faculty must also request Faculty Serious Illness & Disability Leave.**

| Employee's Signature | Date |
|---|---|
| | |

Supervisor's Acknowledgment of Request for Leave

| Supervisor's Signature: | Date |
|---|---|
| | |

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## V. ROUTING OF DOCUMENTATION

Submit this Leave Request Form along with Medical Certification Form(s) and any supporting documentation to:
Attention: Benefits Consultant, Office of Human Resources (OHR), Lumbee Hall Suite 347, PO Box 1510, Pembroke, NC 28372
Fax: 910.521.6553 / Tel: 910.521.6279

**FACULTY:**
**In addition to submission of this form with Medical Certification to the OHR, you must also submit the Serious Illness & Disability Leave for Faculty Request Form to your Department Chair.**

## VI. FOR OFFICE USE ONLY

| | | | | |
|---|---|---|---|---|
| **Family & Medical Leave:** | ☐ Approved | ☐ Denied | ☐ N/A | **Notes/Comments** |
| ***Family Illness Leave:** | ☐ Approved | ☐ Denied | ☐ N/A | |
| **Signature – Human Resources:** | | | | **Review Date:** |

*Note: If eligible for FMLA, the employee must exhaust FMLA prior to using the Family Illness Leave option.