

The University of Alabama System Office (UAS)
Leave Request Form

Full Name (Please print/type): _____ Supervisor's Name _____

Department: _____ Phone Number: _____

Requested Leave Start Date: ____/____/____ Requested Leave End Date: ____/____/____

REASON FOR LEAVE:

(Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Vacation/Annual Leave | <input type="checkbox"/> Bereavement Leave | <input type="checkbox"/> Jury Duty |
| <input type="checkbox"/> Sick Leave | <input type="checkbox"/> Military Leave | <input type="checkbox"/> Family Medical Leave |
| <input type="checkbox"/> Personal Leave | <input type="checkbox"/> Unpaid Leave | <input type="checkbox"/> Other |

NOTE: Requests for leave, other than sick leave, should be submitted at least two days prior to the first day of leave. If an employee is absent for more than one workweek due to illness or health condition that qualifies under Family Medical Leave, this leave may be designated as such unless otherwise noted by the employee. Requests for Family Medical Leave are based on information contained in the UAS Family Medical Leave Policy located on the UAS website at www.uasystem.ua.edu.

REASON FOR FAMILY MEDICAL LEAVE:

- Birth and care of employee's child
- Placement of a child with the employee for adoption or foster care
- Serious health condition of employee
- Serious health condition of employee's spouse, dependent child or parent

If leave is requested for a qualifying family member, please complete the following:

Patient's Name: _____ Relationship of patient to employee: _____

I REQUEST TO TAKE MY FAMILY AND MEDICAL LEAVE OF ABSENCE INTERMITTENTLY, UNDER THE ATTACHED SCHEDULE (Requires written approval of supervisor and/or department head)

I understand that I must first use accrued personal and vacation leave (and accrued sick leave in the case of employee medical condition) at the beginning of my family and medical leave of absence before going on unpaid status. Use of accrued leave will not extend my total family and medical leave of absence beyond 12 weeks. I understand that I must provide proper certification from my health care provider within 15 days of the date of this request. Recertification(s) of medical condition may be requested at a later date. I understand that failure to provide the required certification and/or documents may result in a denial of my family and medical leave of absence. I understand that if I do not return to work after the leave, UAS may recover payments for health insurance made by UAS during my leave of absence. I understand that failure to return to work on the date stated above as the leave end date or that misrepresentation of facts on this form will jeopardize my reinstatement at UAS.

Employee Signature: _____ Date: ____/____/____

I have been advised of this employee's intent to take the indicated leave of absence, and, where appropriate, I approve the request, pending receipt of the appropriate documentation.

Supervisor and/or Department Head: _____ Date: ____/____/____

Department: Attach a copy of relevant sick leave, personal leave, and vacation leave accrual records for monthly paid employees.