Reset Form

UNIVERSITY OF MIAMI

Print Form

REQUEST FOR FMLA LEAVE

It is the policy of the University of Miami ("University") to provide eligible employees with up to 12 workweeks of leave in a 12-month period for specified family and medical reasons, or up to 26 workweeks of leave in a 12-month period to care for a covered service member with a serious injury or illness. To be eligible for FMLA leave, you must have been employed with the University for at least 12 months (which need not be consecutive); and (2) for at least 1,250 hours during the 12-month period immediately preceding the commencement of the leave. Employees should refer to the University's "*Family and Medical Leave*" policy for more information.

***Instructions to Employee**: To request FMLA leave, this form must be completed and submitted through the University's Workday system or directly to Human Resources' designated leave coordinators if you do not have access to Workday. You are expected to comply with the University's policy on notice and requirements for requesting leave. If your need for FMLA leave is foreseeable, you are required to submit your request **at least 30 days** prior to the start of your FMLA leave. If your need for FMLA leave is unforeseeable, you are required to submit your request as soon as practicable. If eligible, you will be required to use accrued sick, floating holidays, and vacation balances during your FMLA leave. If you are enrolled in the Short Term Disability Program, please refer to program guidelines for applicable benefits.*

SECTION I – EMPLOYEE'S INFORMATION

First Name: Middle Initial: Last Name:

ID No. Employee's Title:

Employee's Work Email:

Employee's Personal Email:

Work Telephone: Personal Telephone:

Supervisor's Name: Department:

Date of Hire:

Amount of Leave Request:

I request an FMLA leave of absence beginning on and ending on .

My last day of work will be on . I will return to work on .

Intermittent Leave/Reduced Schedule Leave: Intermittent Leave/Reduced Schedule Leave may not be taken to care for a healthy newborn or for newly placed healthy child following the birth or placement of said child. Are you requesting intermittent leave or reduced schedule leave?

Yes ☐ No ☐

If "Yes," please describe your proposed schedule.

Short Term Disability Program: Are you currently enrolled in the Short Term Disability Program? Yes ☐ No ☐

If yes, do you intend to utilize your short term disability benefits during your leave of absence? Yes ☐ No ☐

SECTION II – BASIS FOR LEAVE
(check all that apply)

☐ 1. Birth of the employee's child or to care for newborn child.

☐ 2. Placement of a child with employee for adoption or foster care.

☐ 3. To care for the employee's family member with a serious health condition. Family member's name is:

☐ 4. The employee's own serious health condition that makes the employee unable to perform one or more of the essential functions of the employee's job.

a. Was the employee's serious health condition caused by a work-related injury? Yes ☐ No ☐

b. Has the employee reported the injury to their supervisor? Yes ☐ No ☐

☐ 5. For any qualifying exigency arising out of the fact that the employee's family member is on (or has been notified of an impending call to) covered active duty in the Armed Forces. Family member's name is:

☐ 6. To care for a family member or next of kin who is covered service member with a serious injury or illness. Family member's name is:

SECTION III – ACKNOWLEDGMENT

I hereby acknowledge that I have read and understood the University's policy entitled "*Family and Medical Leave,*" and agree to fully comply with said policy. I further acknowledge that the information provided above is accurate and this Request for FMLA Leave is not being submitted to obtain a benefit for which I am not entitled to receive.

Employee's Signature: _____

Date: _____

NOTE: An employee is not required to submit this form to their supervisor. This form must be signed, and submitted directly to Human Resources.