EASTERN MICHIGAN UNIVERSITY™

Request for Leave of Absence (STAFF)
FMLA + Covid-19

INSTRUCTIONS: Read the vacation, sick time, and leave of absence provisions in the appropriate collective bargaining agreement and/or applicable University policies before completing this form. **To request a leave,** complete sections A, B, C, D and E. **Submit the completed form** to 140 McKenny Hall, Human Resources. **FAX to 734-487-7590** or email. **Attach any supporting documentation indicated as necessary.** Approval or denial notice will be sent via email after the request for leave has been reviewed.
Questions may be directed to 734-487-3195 or HR_Benefits@emich.edu.

A. EMPLOYEE INFORMATION (Please print clearly in ink.)

Name (last, first, m.i.)	Department Name		Indicate Status: ☐ Part-time ☐ Full-time
Employee ID	**E Class**	**Date of Hire**	**Work Phone**
Permanent Address (street, city, zip)			**Home Phone**
Address While On Leave if Different From Permanent Address		**Current Supervisor Name**	

B. LEAVE REQUEST INFORMATION

☐ Initial Request ☐ Extension of Leave Request	**Dates:** **From:** **To:**	**Last Day Worked:**	**Indicate Percent of Leave you are taking:** ☐ Full-time Leave ☐ Part-time Leave _____ %

Type of Leave: **(* Supporting documents are needed prior to approval and should be attached to this form when submitted – If Leave of Absence is for Medical or FMLA, see Fitness for Duty Report.)**

☐ **Family Medical Leave*** ☐ **Military*** ☐ **Medical (includes Maternity)*** ☐ **Child Care** ☐ **Personal** ☐ **Other**

FML Reasons:
- ☐ **Birth/adoption***
- ☐ **Care of sick family***
- ☐ **Employee's own illness***
- ☐ **Intermittent FML***

☐ COVID-19 Paid Leave - All must be true

☐ Due to a need for leave to care for my son or daughter who is under 18 years of age as the school or place of care has been closed, or the child care provider of such son or daughter is unavailable.
☐ I am unable to work (or telework). ☐ My supervisor and HR are in agreement I cannot work (or telework).
☐ There are no other suitable person(s) who can provide care for the child(ren).

Child's Name _____ **Child's Age** _____ **(under age 14)**
Child's Name _____ **Child's Age** _____ **(under age 14)**
Child's Name _____ **Child's Age** _____ **(under age 14)**

I (Supervisor) have discussed with our HR Business Partner and have agreement & approval
Supervisor's Signature: _____ **Date:** _____

Employee's Signature: _____ **Date:** _____

C. SHORT TERM DISABILITY/WORKERS' COMPENSATION:

I am eligible to receive short-term disability payments: ☐ **Yes** ☐ **No**

If eligible, I have contacted the short-term disability carrier. ☐ **Yes** ☐ **No**
The Hartford at 1-888-301-5615. Policy # 805191

Is this condition the result of a work-related incident? ☐ **Yes** ☐ **No**

D. BENEFITS (Important! Read carefully.)

If your leave is approved (a) under the Family Medical Leave option or (b) as a regular medical leave, you retain your rights to benefit coverage for up to 12 weeks.

You may be required to use available sick, vacation and/or compensatory time while on leave – check the appropriate collective bargaining agreement or University policy to find out what is applicable.
If not required to use the time, you may elect to use it to maintain an active pay status.

If your leave is other than a Family Medical Leave, or if you are not using available sick, vacation, or compensatory time, *you will not be covered* by University benefits *unless you elect to continue them at your own expense*. Indicate below what you are choosing to do.

1. ☐ **Continue my insurances.** I understand that the Benefits Office will notify me of the rates and payment schedules to maintain benefits.

2. ☐ **Discontinue my insurances.** Upon my return to work, I understand *I must re-enroll within 30 days of my return to work, and that failure to do so will result in the loss of my benefits.*

(NOTE: Failure to select one of the options above will also result in immediate cancellation of insurance in accordance with the collective bargaining agreements and University policies.)

E. PAID/UNPAID STATUS

Review with your department all available time you have accrued to answer this section. Also review all applicable sections of your collective bargaining agreement or work rules to understand required usage before answering the following:

Check all that apply:

☐ **Due to COVID-19 noted on page one, I am requesting to be paid per the Federal guideline.**
> 1st 10 days is unpaid. Indicate if you would like to keep yourself in paid status by marking additional boxes below.
> Thereafter, up to 10 weeks will be paid at not less than two-thirds of my regular rate of pay. No more that $200 per day or $10,000 in total.
> I understand that I have 12 weeks in total for all FMLA related leaves.
> Any previous used FMLA will be deducted from the time available.

☐ **I have completed a separate request form & I do want to use my available Emergency Paid Sick Leave, if applicable.**
EPSL Time Available: 80 hours for FT, prorated for PT.
Indicate amount available _____to be used _____. Pay ending date _____

☐ **I do want to use my available sick time, if applicable.**
Indicate amount available _____to be used _____. Pay ending date _____

☐ **I do want to use my available vacation time, if applicable.**
Indicate amount available _____to be used _____. Pay ending date _____

☐ **I do want to use my available compensatory time, if applicable.**
Indicate amount available _____to be used _____. Pay ending date_____

☐ **I do want to use my available sick bank, if applicable.**
Indicate amount available _____to be used _____. Pay ending date_____

HUMAN RESOURCES

To extend this leave: **Appropriate documentation must be submitted *in advance* of the approved end date above (see Medical Certification of Health Care Provider Addendum Form). Fax # 734-487-7590**

To return to work: **Notify Human Resources two weeks *prior to end of leave* to confirm return to work date.**

Questions may be directed to: Benefits Office (734) 487-3195 or HR_Benefits@emich.edu Payroll Office (734) 487-2393