University of Idaho

Application for Family Medical Leave (FSH3710)

Updated 01-2018

Employee: Please submit your completed and signed request to Benefit Services at least 30 days in advance of the need for leave when the leave is foreseeable. If your need for leave is not foreseeable, please submit this form as early as possible. The employer reserves the right to deny or postpone leave for failure to give appropriate notice when such a denial or postponement would be permitted under federal or state law. Send to: Benefit Services at Campus Zip: 4332, Email to Benefits@uidaho.edu or Fax to 208-885-3330.

Name:	**Vandal Number:**	**Department and Supervisor Name:**
Phone Number: Work: Home:	**Email Address:** Work: Home:	**Emergency Contact:** Name: Phone #:

Have you taken FMLA before?	**Date leave is expected to begin:**	**Date leave is expected to end:**	**Leave will be taken as:**
☐ Yes ☐ No			☐ Continuous leave ☐ Intermittent leave ☐ Reduced schedule

If requesting a reduced schedule, please provide the proposed work schedule here:

Mon _____Tues _____Wed _____Thurs _____Fri _____Sat _____Sun _____

Reason For Leave: * Please see the FSH3710, A-3 for the University of Idaho definition of an "immediate family member"

- ☐ The birth of a child, or placement of a child through adoption or foster care (parenting)
- ☐ A serious health condition that makes you unable to perform the functions of your job
- ☐ Need to care for an immediate family member* who has a serious health condition
- ☐ *Military Caregiver Leave* – Care for an immediate family member* who is also a covered service member who has become seriously ill or injured while on active duty
- ☐ *Military Caregiver Leave* - Qualifying exigency arising out of the fact that an immediate family member* has been called to active duty as a member of the National Guard or Reserves

Indicate leave you are planning to use: Sick _____ Comp Time _____ Annual _____ LWOP _____**

****If utilizing (LOWP) Leave Without Pay, you must make arrangements with the Benefit Services to pay for your benefits. Required payments are outside of payroll deduction and are not pre-tax.**

Please indicate whether your spouse is also an employee of the University of Idaho and may also need leave:

- ☐ No
- ☐ Yes Spouse's Name_____Department: _____

Signatures: Please notify your supervisor of the intent to take Family Medical Leave. You do NOT need to share specific medical information with your supervisor or department.

Employee: _____ Date: _____

Human Resources Use Only

FMLA Qualified Y ☐ N ☐ Med Cert Received Y ☐ N ☐ Eligibility and Docs Needed notice sent Y ☐ N ☐

Notes: _____

Recertification/More Info Needed Y ☐ N ☐ Shared Leave Requested Y ☐ N ☐ FMLA Approved Y ☐ N ☐

Designation Notice Sent To Employee Y ☐ N ☐ Supervisor Y ☐ N ☐ LWOP Payment Contact: Y ☐ N ☐

Return to Work: Y ☐ N ☐ Date: _____ Total FMLA Leave Used _____