REQUEST FOR LEAVE OF ABSENCE - UTime

Information on this form is confidential and private

Employee Instructions: It is your responsibility to ensure this form is submitted 30 days in advance of your expected leave date. Complete your portion of this form, then meet with your direct supervisor for them to complete their portion. Forms and additional information are located at www.unh.edu/hr/leave-of-absence.

First Name: _____ Last Name: _____

Employee ID #: _____ Department: _____ Job Title. _____

Leave Reason – Please check all that apply	**Instructions**
☐ Medical – for your own medical condition *Is medical leave due to the birth of your child?* ☐ Yes ☐ No	File your claim with Sun Life at 888-444-0239
☐ Medical - due to your work-related injury (Workers' Compensation)	Confirm that your WC medical report is on file with HR
☐ Care for an immediate family member with a serious health condition ☐ spouse ☐ child ☐ parent	File your claim with Sun Life at 888-444-0239
☐ Parental (Bonding) Leave – care for a child within the first 12 months of life or first 12 months of foster care/adoption placement	File your claim with Sun Life at 888-444-0239
☐ Personal Leave (if none of the above apply)	Contact your HR Partner
☐ Military Leave - for self or family member	Contact HR Benefits

Expected Dates of Leave: **Expected dates must be entered and it is understood that these dates could change.**

I request a consecutive leave beginning _____/_____/_____ and I expect to return _____/_____/_____

I request an intermittent leave beginning _____/_____/_____ and I expect it to end _____/_____/_____

Employee Acknowledgement: I understand that this form is a request for a leave of absence and not an approval. I will receive notice from the HR Department regarding the approval of this request including any rights I may have under the federal Family & Medical Leave Act (FMLA). I understand that if I do not provide the required documentation to support this request in a timely manner it may result in loss of some or all of my leave benefits.

Employee Signature: _____ Date: _____/_____/_____

Supervisor Instructions: Complete the bottom part of this form entirely. Be sure the employee understands where they can locate additional information. Once this form is completed, with appropriate signatures, you need to provide a copy to the employee & email a copy to your Finance Contact & to HR Benefits at hr.benefits@usnh.edu

Supervisor Acknowledgement: By signing below you are acknowledging receipt of this request. The HR Benefits Department will notify the employee of approval and provide information of any benefits available under the federal Family and Medical Leave Act (FMLA) if applicable. You will be copied on all correspondence.

Supervisor/Chair Name: _____ Date: _____/_____/_____

Supervisor/Chair Signature: _____ Date: _____/_____/_____