Request for Family/Medical Leave

Name: _____ Personnel Number: _____

Campus Address w/ ZIP: _____ Phone: _____

Department: _____ Supervisor's Name: _____

1. I request family/medical leave beginning _____ and continuing through _____ for the following purpose:
   - ☐ the birth of my child or the placement of a child with me for adoption or foster care.
   - ☐ a serious health condition that makes me unable to perform the essential functions of my job.
   - ☐ a serious health condition affecting my spouse, child, or parent for which I am needed to provide care.
   - ☐ the death of an immediate family member. (*i.e. spouse, parent, son or daughter)*)
2. Total hours of anticipated absence from UNL is 0.00. This leave is to be ☐ Paid ☐ Unpaid ☐ Combination.
3. Please provide the number of hours of each type of leave to be taken.

   Vacation: _____ Sick: _____ Funeral: _____ Unpaid: _____
4. If leave of three consecutive days or more has been taken for any of the above listed purposes within the past 12 months, please indicate the dates: _____
   Please note that leave of three (3) consecutive days or more taken for any of the above listed reasons may apply toward the twelve weeks of eligibility for leave provided under the Family/Medical Leave Act.

I understand:

a. **That I may be requested to provide medical documentation of my illness or the illness of my immediate family member**
b. **That I may be requested to provide a medical release upon my return to work**
c. **That I am responsible to consult UNL Benefits Office for any unpaid portion of this leave.**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

_____ _____

Employee signature Date Approval of Immediate Supervisor Date

_____

Approval of Dean/Director Date

Note to Dean/Director: Please send completed original forms to Human Resources and copies to employee and department respectively.

University of Nebraska Lincoln

Department of Human Resources
407 Canfield Administration Building South | Lincoln, NE 68588-0438 | 402.472.3101
hr.unl.edu

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