



## 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 \_\_\_\_\_. 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.