Northern Illinois University
Human Resource Services

MEDICAL LEAVE REQUEST FORM

To receive a Family Medical Leave Act (FMLA) information packet and full application, please complete the following form and send to NIU Human Resources, 1515 W. Lincoln Hwy, DeKalb, Illinois 60115, fax to (815) 753-6074, or send via email to fmla@niu.edu.

Human Resource Services will notify you within five business days of the receipt of this form of your eligibility for FMLA. At that time, an information packet and the necessary forms will be provided.

Upon receipt of this form, Human Resource Services will notify your supervisor of your request for leave, including your general reason for leave, if the leave is for yourself or a family member, your type of leave (continuous or intermittent), and the estimated dates of your leave as you indicate below. Specific medical conditions/information will not be shared.

Employee Information

Name: _____ Employee ID: _____
Preferred Phone Number: _____ Preferred Email Address: _____
Preferred Method of Contact (please check one): Phone: _____ or Email: _____
Department: _____ Supervisor's Name: _____
Employment Type (please check one): Faculty: _____ SPS: _____ Civil Service Salaried: _____ Civil Service Hourly: _____
Employment Status (please check one): Full-time: _____ Part-time: _____ If Part-time, please list percentage: _____

Reason for Leave (please check one)

Birth and Care of Newborn Child: _____ Estimated Due Date: _____
Placement for Adoption or Foster Care: _____ Estimated Date of Placement: _____
Employee's Own Serious Health Condition: _____
Care for Spouse, Civil Union Partner, Domestic Partner, Child or Parent with Serious Health Condition: _____
Name of Family Member: _____ Relationship: _____
Care for Covered Service Member (Spouse, Civil Union Partner, Domestic Partner, Child Parent, or Next of Kin) with a Serious Illness or Injury: _____
Name of Service Member: _____ Relationship: _____
Qualifying exigency arising from Spouse, Civil Union Partner, Domestic Partner, Child or Parent on covered active duty or called to active duty: _____
Name of Service Member: _____ Relationship: _____

Type of Leave (please check all that apply)

Continuous Leave (3 consecutive days or more): _____
Intermittent Leave (Scheduled/or sporadic days): _____
Reduced Schedule (Set hours per day): _____

Dates for Which Leave is Being Requested

Estimated Begin Date of Leave: _____**
Estimated End Date of Leave: _____
Last Day Worked: _____

Benefit Designation (please rank order - 1,2,3) how you wish to utilize your accrued benefits (subject to availability & University policies):

Sick Leave: _____
Vacation: _____
Compensatory Time (hourly only): _____
Comments on Benefit Usage: _____
_____

**Please note, if foreseeable, requests for medical leave should be made at least thirty (30) days in advance of the leave or as soon as practicable. If the need for leave is not foreseeable, requests should be made within two business days of learning of the need for leave. If the Estimated Begin Date for Leave listed above is not more than thirty (30) days in the future, please indicate on the lines below the reason for the delay in notification:

_____
_____
_____

FMLA Packet (Please indicate how you would like to receive your FMLA Packet)

Email: _____
Pick-up at Human Resource Service Center: _____
Mailed to me at the Following Address: _____

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Employees must follow their departmental call-in procedures for any absences until their requests for leave has been received, reviewed, and approved. A notification will be sent to the employee and their supervisor upon approval of the leave request.