REQUEST FOR LEAVE OF ABSENCE (Form 1001)

Staff Member Completes Sections 1 and 2
Supervisor/Manager/Department HR Completes Section 3

Section 1: PERSONAL INFORMATION (Staff Member completes Sections 1 and 2 and returns completed form to Supervisor/Manager)		
Last Name:	**First Name:**	**Duke Unique ID:**
Home Address:	**Work Phone:**	**Department:**
Date Submitted:	**Home Phone:**	**Job Title:**
Signature:	**E-mail:**	**CSD/Hire Date:**

Section 2: STAFF MEMBER: Check the type of leave and provide documentation as indicated

I request that my leave begin on _____ and end on _____. (If necessary, give approximate dates.)

Family Medical Leaves (required medical certifications must be returned within 15 days of receipt)		
☐	**Employee Illness**	**Certificate of Health Care Provider (Form 1002-E)**
☐	**Child/Parent/Spouse Illness**	**Certificate of Health Care Provider for Family Member's Illness/Injury (Form 1002-F)**
☐	**Maternity**	**Certificate of Health Care Provider (Form 1002-E)**
☐	**Paternity** *(Must be taken within one year of birth)*	**Certificate of Health Care Provider (Form 1002-F)**
☐	**Adoption/Placement of Foster Child** *(Must be taken within one year of placement)*	**Letter of Placement**
☐	**Military Caregiver**	**Certification for Serious Illness or Injury of Covered Service Member (DOL WH-385-V)**
☐	**Military Exigency**	**Certification of Qualifying Exigency (DOL WH-384)**
Personal Leaves (not FMLA eligible or not FMLA related)		
☐	**Educational**	**Letter of Acceptance from Educational Institution**
☐	**Medical (non-FMLA)** *(Only available for staff member's own illness/injury)*	**Certification from Health Care Provider** *(Must include date condition began, probable duration, facts regarding staff member's medical condition and inability to work)*
☐	**Military (non-FMLA)**	**Department of Defense Orders**
☐	**Maternity (not eligible for FMLA)**	**Certification from Health Care Provider** *(including expected delivery date)*
☐	**Paid Parental Leave** *(May run concurrently with FMLA)*	**Primary Caregiver Affidavit for Paid Parental Leave**
☐	**Other Personal**	**Explanation of Request**

Section 3: SUPERVISOR/MANAGER/DEPARTMENT HR: Complete this section		
Name (Print):	**E-mail:**	
Signature:	**Phone:**	**Date:**
Name(s) and E-mail(s) of any others to receive Determination Form:		

Check entity where Staff Member is employed:		
☐ **DUH – Duke University Hospital**	☐ **DUHS – Company 20, Corporate Services**	☐ **DPC**
☐ **AHS/DASC**	☐ **University – includes SOM, SON, DCRI**	☐ **PDC**
☐ **DRH – Duke Regional Hospital**	☐ **CFL – Health & Wellness**	☐ **DHCH**
☐ **DRaH – Duke Raleigh Hospital**	☐ **Labco – DUHS Clinical Labs**	☐ **PRMO**

If this leave is for a Family Medical Leave:

(1) Has Staff Member had absences counted towards FMLA entitlement in the past 12 months? ☐ **YES** ☐ **NO**

If so, provide dates/hours which have already been applied towards FMLA, along with supporting documentation

Dates: From _____ to _____ Total hours of FMLA utilized during the past 12 months: _____

(2) If approved, will this leave be taken on an intermittent basis? ☐ **YES** ☐ **NO**
(Not available for adoption, placement in foster care or Paternity leave; only available for maternity leave if medically necessary)

(3) Leave dates approved by EOHW Determination Form From _____ To _____