

Request for Leave of Absence

To be completed by employee. (Please type or print)

1. Name of employee

Last Name	First Name	M.I.
-----------	------------	------

2. Employee's Position/Department _____

3. Reason for requested leave (Please check the appropriate box) :

- A. Family and Medical Leave [up to 12 weeks]
 - 1. Birth of my child and/or to care for the newborn child
 - 2. Placement of child with me for adoption or foster care
 - 3. To care for my family member* with a serious health condition
 - 4. My own serious health condition

- B. Extended Medical Leave [leave exceeding an initial 12 weeks for employee illness]

- C. Personal Leave (Please state reason below)

D. Military Leave

4. If A(1) or A(2) is checked, give date of birth or placement: _____

5. If A(3) is checked, please specify your relationship to the family member: _____

6. If A(3) is checked, please state name and address of family member:

7. Date on which you wish to commence leave: _____

Date of anticipated return to work: _____

8. Are you requesting leave on an intermittent/reduced leave schedule [Yes/No]? _____

9. If "Yes", please give schedule of when you anticipate you will be available for work

* includes spouse, child, parent, or eligible domestic partner. Refer to Policy C 6.00 for specific definitions.

Request for Leave of Absence

If I am seeking leave because of reason A(3), A(4) or B, I will return a completed Medical Certification form within 15 days, or as soon as practicable. I understand that my leave may be delayed until I provide this documentation. Thereafter, I must recertify this medical condition every 30 days by submitting a physician's statement to Human Resources.

I understand that when I want to return to work after a leave because of my own serious illness, I must have my physician complete the attached Return to Work Medical Certification and I must give it to my supervisor before I will be allowed to resume work.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums. If I am unable to return to work following an initial leave because of a serious health condition, I will request an extended medical leave and provide a medical certification from the appropriate health care provider starting that I am unable to perform the functions of my position on the date that my leave expired. If I am unable to return to work following a leave because I am needed to care for a covered family member because he/she has a serious health condition on the date my leave expired, I will request approval for a personal leave and provide medical certification from the appropriate health care provider.

I am requesting to be absent from work for the reason and period of time stated herein. I understand that if I return to work from a Family and Medical leave within 12 weeks, or longer if accrued sick leave is not yet exhausted in cases of personal medical disability, I may be returned to my prior position or equivalent position at IIT. If I return from a personal leave within 8 weeks, the same will apply. Beyond these timeframes, I understand that IIT cannot guarantee that a position will be available.

I will notify the Director of Human Resources in writing of my intent to return to active status **at least two weeks prior to my return**. I understand that if I do not contact IIT within three days following the end of my leave, it will be determined that I have elected to resign.

I intend to draw down the following earned time (check all that apply):

Vacation Personal business days Personal floating holiday

Signature

Date

Approvals

Department Head

Human Resources