



Preparing people to lead extraordinary lives

## Loyola University Chicago Request for Family Medical Leave (FMLA)

Name: \_\_\_\_\_ Department: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Start Date of Anticipated Leave: \_\_\_\_\_

Expected Date of Return to Work \_\_\_\_\_

Reason for Leave (Explain): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**NOTE: An employee requesting leave for the employee's own serious health condition or the serious health condition of the employee's spouse, child or parent must submit a verifying medical certification from a physician within 15 days of submitting this application for leave.**

I authorize a health care provider representing Loyola University Chicago to contact my physician to verify the reason for my requested family and medical leave

I hereby acknowledge that a failure to return to work at the conclusion of my leave will be deemed a resignation from employment, unless the company approves a leave extension and records such approval in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

APPROVED BY:

\_\_\_\_\_ Date: \_\_\_\_\_

Department Head/Supervisor

\_\_\_\_\_ Date: \_\_\_\_\_

Human Resources