East Carolina University

Request for Faculty Serious Illness Leave and Parental Leave And FMLA Leave

NOTE: Refer to the appropriate policies for more information on eligibility and restrictions.

Date of Request:	☐ New Request	☐ Revision of Previous Request

I. EMPLOYEE DATA

Employee Name:		**DOB**	
Dept Name:		**Dept #:**	
Banner ID #:		**Work Phone:**	
Home Address:		**Home Phone:**	
Supervisor:		**Phone:**	

II. MEDICAL CONDITION INFORMATION

Leave Selections (check all that apply):

☐ Family & Medical Leave Only

☐ NC Family Illness Leave

☐ Faculty Serious Illness & Parental Leave *

☐ Military Caregiver/Qualified Exigency *

* For Military Caregiver/Qualified Exigency and Faculty Serious Illness & Parental Leave, Family & Medical Leave is automatically included and must be taken concurrently if the Employee is eligible for FMLA coverage.

Is another ECU employee eligible for leave due to this event?
☐ **NO** ☐ **YES Name:**_____

Reason(s) for Requiring Leave:

☐ Serious Health Condition of the Employee

☐ Serious Health Condition of a:

☐ Parent ☐ Child ☐ Spouse ☐ Covered Military Member

☐ Qualified Exigency for National Guard or Reserves

☐ New Child:
Are you the Secondary Caregiver? ☐ YES ☐ NO

☐ Birth ☐ Adoption ☐ Foster Care Placement

Attach Medical Certification Form(s) if required:	Second Medical Certification Required? (required if exact date of qualifying event is unknown) ☐ YES ☐ NO	Have you taken any medical leave in the past 12 months? ☐ YES ☐ NO

If requesting a leave of absence:	Start Date:		End Date:	
Is exact date of qualifying event unknown?	☐ YES ☐ NO			
If requesting a reduced work schedule:	Start Date:		End Date:	
If requesting an intermittent work schedule:	Start Date:		End Date:	
Expected Frequency and Duration of Absences:				

Are you currently receiving benefits from Disability Income Plan of NC or Workers Compensation? ☐ YES ☐ NO

III. Employee Signature

I hereby certify the information I have provided is accurate and complete and that I have read the ECU policies applicable to my leave request. I understand that I must submit a "Medical Release to Return to Work" completed by my physician to the Benefits Office before I can return to work. I agree to notify my supervisor immediately if the date I am able to return to work changes for any reason, or if I should decide not to return to my present position. I understand that failure to report for work at the expiration of my approved leave, unless an extension has been granted, will be considered neglect of duty and will subject me to the imposition of serious sanctions pursuant to Section VI of Appendix D of the ECU Faculty Manual.

Employee's Signature	Date

IV. For Tenure Track Faculty Only

I understand that if I am approved for any medical leave, I may be eligible for an extension of my probationary term pursuant to Appendix D of the ECU *Faculty Manual* ("Appendix D"). I further understand that in order to request an extension I must do so in writing to my Unit Administrator and that it is my responsibility to do so. I further understand that I will not be discriminated against or penalized in any way for requesting or receiving any medical leave and/or an extension. By signing below I acknowledge **that this request for medical leave is not a request for an extension of my probationary term** and that I have read and understand Section II(C)(4) of Appendix D and Section 7.2 of the Faculty Serious Illness and Parental Leave Policy. I understand that if my circumstances change, I may request an extension at that time. Alternatively, if I decide later I do not wish to extend my probationary term, expressing an intent to do so now does not obligate me to proceed with that request. As of this date, my intension is as follows:

☐ **I intend to request a Probationary Term extension** ☐ **I do not intend to request a Probationary Term extension**

Employee's Signature	Date

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V. DEPARTMENTAL NOTIFICATION

Below to be completed by Unit Administrators prior to submitting to ECU Benefits Coordinator to acknowledge the faculty member's notification of anticipated absence and projected duration. By signing below Administrators certify that the faculty member's contract covers the period of requested leave.

Department Chair or Immediate Supervisor Signature	Dean or Secondary Supervisor Signature
Date	Date

Return this Leave Request Form along with Medical Certification Form(s), Leave Records, and any supporting documentation to: **East Campus**—Human Resources, Benefits Unit OR **Health Sciences** –Human Resources, Benefits Unit, Brody 2E-67

VI. FOR OFFICE USE ONLY

Anticipated Leave Approved:		Start Date:	End Date:	
Total Leave Approved:		Start Date:	End Date:	
Period of Leave without Pay:		Start Date:	End Date:	
FSIL Leave Designation:		Start Date:	End Date:	
FMLA Leave Designation:		Start Date:	End Date:	
Appointment:	☐ Permanent ☐ Temporary	☐ EPA 9-mo Faculty ☐ EPA 12-mo Faculty ☐ Other_____	☐ Full-Time ☐ Part-Time – Hrs/Wk:	
Benefits Coordinator:			**BC Phone:**	

Faculty Parental Leave:	☐ Approved	☐ Denied	☐ N/A	**Notes/Comments:**
Faculty Serious Illness/Disability Leave:	☐ Approved	☐ Denied	☐ N/A	
Family & Medical Leave:	☐ Approved	☐ Denied	☐ N/A	
Family Illness Leave:	☐ Approved	☐ Denied	☐ N/A	
Signature – Human Resources:				**Review Date:**