

# REQUEST FOR LEAVE OF ABSENCE OR MODIFIED WORK SCHEDULE

## Personal Medical, Family Medical, Disability, or Parental Leave

This form is used when an employee is requesting leave or a modified or reduced work schedule because of a personal serious health condition, to care for a family member with a serious health condition or to request parental leave. Complete the portions of this form that are relevant to your request and submit the form to your supervisor.

Leave Request Information	
Duration of Requested Leave of Absence  Leave Start Date: _____  Leave End Date: _____  *Definitions for terms are on page two of this document	Reason for Request (see page 2 for health condition definitions) <input type="checkbox"/> Personal serious health condition* Is leave due to a work related injury/illness <input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <input type="checkbox"/> Family member serious health condition*, or emergency condition*: Relationship of family member _____ <hr/> <input type="checkbox"/> Child with health condition requiring treatment* or supervision*: Child's age: _____ <hr/> <input type="checkbox"/> Parental Leave    Anticipated date of birth/placement: Date: _____

For leave of absence request, please specify the types of leave you wish to use and the dates on which you wish the leave to apply and the total leave hours of each type of leave.

<input type="checkbox"/> Sick Leave			<input type="checkbox"/> Vacation Leave			<input type="checkbox"/> Compensatory Time			<input type="checkbox"/> Leave Without Pay		
From Date	To Date	Hrs	From Date	To Date	Hrs	From Date	To Date	Hrs	From Date	To Date	Hrs
<b>Total SL hrs</b>			<b>Total VL hrs</b>			<b>Total Comp Time hrs</b>			<b>Total LWOP hrs</b>		

I wish to use my personal holiday on: (date) \_\_\_\_\_

Request for Modified Work Schedule	
I request that my work schedule be: <input type="checkbox"/> Modified <input type="checkbox"/> Reduced	Please specify the work schedule change you are requesting. Attach additional sheet if necessary.

_____ Print Name	_____ Employee Signature (date)
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Employees may be asked to provide a statement from their health care provider confirming the medical necessity for the leave request. If a health care provider statement is requested, you will be given the appropriate form for your health care provider to complete. If health care provider certification is requested, approval of the leave request is contingent on receipt of the health care provider certification form.

Requests for parental leave must be accompanied by a statement from the health care provider or the appropriate agency confirming the date of birth or placement.

Approval	
_____ Supervisor Signature (date)	_____ Department Manager/Unit Head (If required) (date)

NOTE: An employee's request for parental leave or leave due to a serious health condition or family member's health condition may not be denied without prior consultation with your unit's Human Resources Consultant.

A copy of all requests for leave without pay of 10 days or more must be sent to the Human Resources Operations Office.

## Health Condition Definitions

### **Serious health condition means:**

A "serious health condition" is defined as illness, injury, impairment, or physical or mental condition that involves one of the categories described below:

- Inpatient care in a hospital, hospice or residential medical care facility, or subsequent treatment in connection with inpatient care.
- Incapacity for more than 3 consecutive days, involving treatment 2 or more times by a health care provider, by a provider of health care services (e.g., nurse, physician's assistant, physical therapist) under orders of, direction of, or referral by a health care provider, and any subsequent incapacity or treatment related to the same condition.
- Incapacity for more than 3 consecutive days, involving treatment at least once by a health care provider which results in a regimen of continuing treatment under supervision of a health care provider.
- Any period of incapacity due to pregnancy or prenatal care.
- A chronic condition requiring periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider, which continues over an extended period of time, and which may cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).
- A permanent or long-term period of incapacity due to a condition for which treatment may not be effective, but for which the patient is under the continuing supervision of a health care provider. The patient may not be receiving active treatment for the condition (e.g., Alzheimer's, severe stroke, terminal stages of a disease.).
- A period of absence to receive multiple treatments (or recovery therefrom) by a health care provider, or by a provider of health care services on referral by a health care provider, either for restorative surgery after an accident or injury, or for a condition that would likely result in a period of incapacity of more than 3 consecutive calendar days in the absence of medical intervention or treatment (e.g., chemotherapy, radiation, dialysis.).

### **Health condition requiring treatment or supervision means:**

- Any medical condition requiring treatment or medication that the child cannot self administer;
- Any medical or mental health condition which would endanger the child's safety or recovery without the presence of a parent or guardian; or
- Any condition warranting treatment or preventive health care such as physical, dental, optical or immunization services, when a parent must be present to authorize and when sick leave may otherwise be used for the employee's preventive health care.

### **Emergency condition means:**

A health condition that is a sudden, generally unexpected occurrence or set of circumstances related to one's health demanding immediate action, and is typically very short term in nature.

### **Incapable of self-care means:**

The individual requires active assistance or supervision to provide daily self-care in several of the "activities of daily living" (ADLs) or "instrumental activities of daily living" (IADLs). Activities of daily living include adaptive activities such as caring appropriately for one's grooming and hygiene, bathing, dressing and eating. Instrumental activities of daily living include cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, using a post office, etc.

### **Physical or mental disability means:**

A physical or mental impairment that limits one or more activities of daily living or instrumental activities of daily living.

## Information about Disability Accommodation

Employees who have a health condition that prevents them from doing any of the "essential functions" of their position for more than a brief period of time should familiarize themselves with the process for requesting disability accommodation. This information is published on the web at:

<http://www.washington.edu/admin/hr/pol.proc/accommodation/accom.request.instr.html>