



# DESIGNATION/REQUEST FOR LEAVE OF ABSENCE

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

Department: \_\_\_\_\_ Extension: \_\_\_\_\_

- Birth of Child** Expected Birth of Child: \_\_\_\_\_  
 Leave to Start: \_\_\_\_\_ Expected Return Date: \_\_\_\_\_  
 Spouse employed by Loyola  Yes  No
- Adoption of Child** Expected Adoption Date of Child: \_\_\_\_\_  
 Leave to Start: \_\_\_\_\_ Expected Return Date: \_\_\_\_\_  
 Spouse employed by Loyola  Yes  No
- Placement of Child for Foster Care** Expected Placement Date of Child: \_\_\_\_\_  
 Leave to Start: \_\_\_\_\_ Expected Return Date: \_\_\_\_\_  
 Spouse employed by Loyola  Yes  No
- Employee's Serious Health Condition**  
 Leave to Start: \_\_\_\_\_ Expected Return Date: \_\_\_\_\_  
 Spouse employed by Loyola  Yes  No
- Family Serious Health Condition**  Child  Spouse  Other **Name** \_\_\_\_\_  
 Leave to Start: \_\_\_\_\_ Expected Return Date: \_\_\_\_\_  
 Spouse employed by Loyola  Yes  No
- Military Exigency Leave**  Spouse: Name \_\_\_\_\_  
 Leave to Start: \_\_\_\_\_ Expected Return Date: \_\_\_\_\_  
 Spouse employed by Loyola  Yes  No
- Covered Service Member Leave** Member Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Leave to Start: \_\_\_\_\_ Expected Return Date: \_\_\_\_\_  
 Spouse employed by Loyola  Yes  No

**Certification of Physician or Practitioner Form** (available online or in the HR office) must be returned to Human Resources Benefits Department within 15 days of the date of your request for leave. If it is not provided within 15 days from the date of request, your leave will be cancelled.

Have you taken family medical leave in the past 12 months?  Yes  No  
If yes, how many work days? \_\_\_\_\_

**I understand and agree to the following provisions:**

1. To be eligible for unpaid 12-week Family Medical Leave (26-week Covered Service Member Leave, please contact HR) I must have worked for my employer at least one year and at least 1,250 hours in the previous 12 months.  
 I am required to exhaust my accrued sick and vacation leave (for a serious medical condition for myself, and may use 20 days of sick time for a spouse, child, or parent) as part of an eligible 12 weeks of Family Medical Leave.
2. To be eligible for Parental Leave I must have worked for my employer at least six months.  
 I am required to use my sick and vacation leave after paid parental leave according to university policy (for birth, adoption, or foster placement of a child) as part of an eligible 12 weeks of Family Medical Leave.
3. If I fail to return to work after the leave for reasons other than the continuation, recurrence or onset of a serious health condition that would entitle me to Medical Leave or other circumstances beyond my control, I will be financially responsible for my portion of the medical insurance premiums the company paid while I was on leave.
4. After my allowed leave, if I do not return to work or contact my supervisor or manager on the date intended, it will be considered that I abandoned my job.

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