Print Form

ILLINOIS INSTITUTE OF TECHNOLOGY

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 *(Pleas 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.*

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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 Human Resources at least 2 days prior to my return to 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 Sr. Compensation & Benefits Consultant 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/Floating holiday ☐ Sick (if applicable)

Signature Date

Acknowledgment of Pending Leave

Department Head (name) Signature Date

Human Resources