MEDICAL LEAVE REQUEST FORM

TEAMMATE INFORMATION:	
TEAMMATE NAME:	JOB TITE:
AGENCY & DIVISION:	SUPERVISOR:
PERSONAL PHONE NUMBER:	PERSONAL ADDRESS:
	CITY/STATE:
	ZIP CODE:

STEP 1: PROVIDE DATES NEEDED OFF *(if exact dates are unknown, provide estimates)*

- ☐ My leave will be for a continuous period of time – exact dates determined
- ☐ My leave will be on an as needed basis – exact dates and hours unpredictable

START DATE:	RETURN DATE:

STEP 2: PROVIDE REASON FOR LEAVE

- ☐ I am the mother or father of a newborn child.
  Estimated due date:
- ☐ I am adopting or have legally adopted a child.
  Expected adoption date:
- ☐ Placement of a foster child in my home.
  Expected placement date:
- ☐ I am or will be caring for my seriously ill mother or father.
  Name of parent:
- ☐ I am or will be caring for my seriously ill spouse.
  Name of spouse:
- ☐ I am or will be caring for my seriously ill child.
  Name of child:
  Age of child:
- ☐ Personal request due to my own serious health condition or injury (would include recovery from childbirth or extended pre-natal care)
- ☐ Qualifying Exigency: when leave arises out of the foreign deployment of teammate spouse, son, daughter, or parent
- ☐ Military Caregiver Leave of a Current Services Member: when requesting leave to care for a family member who is a current services member with a serious injury or illness.
- ☐ Military Caregiver Leave of a Veteran: when requesting leave to care for a family member who is a covered veteran with a serious injury or illness.
- ☐ Other:

PREFERRED COMMUNICATION METHOD (select all that apply) *There are several documents involved in the medical leave process. How do you prefer to receive the documents?*

☐ State of Nebraska Work Email

☐ Personal Email
Provide personal email address:

☐ USPS Certified Mail

DO YOU WANT HR TO FAX THE MEDICAL DOCUMENTATION DIRECTLY TO THE TREATING PHYSICIAN?
Specific medical information is required. HR can help you complete this requirement by faxing the requested information to the treating physician.

☐ YES – please fax the medical request form to the treating physician
Doctor Name:
Address:
Fax Number:
Phone Number:

☐ NO – Send the blank forms to me. I will deliver the forms to the treating physician.

PAID TIME OFF & LEAVE DONATIONS: *If eligible, are you interested in receiving leave donations?*

☐ YES
☐ NO
☐ Maybe, I'd like more information.

STEP 3: SIGN AND DATE REQUEST

_____ _____
Teammate signature Date signed

STEP 4: SEND COMPLETED REQUEST FORM TO THE HR SHARED SERVICES TEAM
***If you received this form via DocuSign, submitting this form in that system will automatically route it to the HRSS Team.*