

# REQUEST FOR LEAVE OF ABSENCE

(Form 1001)

Staff Member Completes Sections 1 and 2  
Department Representative Completes Section 3

## Section 1: PERSONAL INFORMATION (Staff Member completes Sections 1 and 2 and returns completed form to Supervisor/Manager)

Last Name:	First Name:	Duke Unique ID:
Home Address:	Work Phone:	Department:
Date Submitted:	Home Phone:	Job Title:
Signature:	E-mail:	CSD/Hire Date:

## Section 2: STAFF MEMBER: Check the type of leave and provide documentation as indicated

I request that my leave begin on \_\_\_\_\_ and end on \_\_\_\_\_. (If necessary, give approximate dates.)

### Family Medical Leaves (required medical certifications must be returned within 15 days of receipt)

<input type="checkbox"/>	Employee Illness	Certificate of Health Care Provider (Form 1002-E)
<input type="checkbox"/>	Child/Parent/Spouse Illness	Certificate of Health Care Provider for Family Member's Illness/Injury (Form 1002-F)
<input type="checkbox"/>	Maternity	Certificate of Health Care Provider (Form 1002-E)
<input type="checkbox"/>	Paternity (Must be taken within one year of birth)	Certificate of Health Care Provider (Form 1002-F)
<input type="checkbox"/>	Adoption/Placement of Foster Child (Must be taken within one year of placement)	Letter of Placement
<input type="checkbox"/>	Military Caregiver	Certification for Serious Illness or Injury of Covered Service Member (DOL WH-385-V)
<input type="checkbox"/>	Military Exigency	Certification of Qualifying Exigency (DOL WH-384)

### Personal Leaves (not FMLA eligible or not FMLA related)

<input type="checkbox"/>	Educational	Letter of Acceptance from Educational Institution
<input type="checkbox"/>	Medical (non-FMLA) (Only available for staff member's own illness/injury)	Certification from Health Care Provider (Must include date condition began, probable duration, facts regarding staff member's medical condition and inability to work)
<input type="checkbox"/>	Military (non-FMLA)	Department of Defense Orders
<input type="checkbox"/>	Maternity (not eligible for FMLA)	Certification from Health Care Provider (including expected delivery date)
<input type="checkbox"/>	Paid Parental Leave (May run concurrently with FMLA)	Primary Caregiver Affidavit for Paid Parental Leave
<input type="checkbox"/>	Other Personal	Explanation of Request

## Section 3: DEPARTMENT REPRESENTATIVE (Supervisor/Manager/Department HR): Complete this section

Name (Print):	E-mail:	
Signature:	Phone:	Date:

Name(s) and E-mail(s) of any others to receive Determination Form:

### Check entity where Staff Member is employed:

<input type="checkbox"/> DUH – Duke University Hospital	<input type="checkbox"/> DUHS – Company 20, Corporate Services	<input type="checkbox"/> DPC
<input type="checkbox"/> AHS/DASC	<input type="checkbox"/> University – includes SOM, SON, DCRI	<input type="checkbox"/> PDC
<input type="checkbox"/> DRH – Duke Regional Hospital	<input type="checkbox"/> CFL – Health & Wellness	<input type="checkbox"/> DHCH
<input type="checkbox"/> DRaH – Duke Raleigh Hospital	<input type="checkbox"/> Labco – DUHS Clinical Labs	<input type="checkbox"/> PRMO

### If this leave is for a Family Medical Leave:

- (1) Has Staff Member had absences counted towards FMLA entitlement in the past 12 months?  YES  NO  
If so, provide dates/hours which have already been applied towards FMLA, along with supporting documentation  
Dates: From \_\_\_\_\_ to \_\_\_\_\_ Total hours of FMLA utilized during the past 12 months: \_\_\_\_\_
- (2) If approved, will this leave be taken on an intermittent basis?  YES  NO  
(Not available for adoption, placement in foster care or Paternity leave; only available for maternity leave if medically necessary)
- (3) Leave dates approved by EOHV Determination Form From \_\_\_\_\_ To \_\_\_\_\_