PERSONAL MEDICAL LEAVE OF ABSENCE REQUEST FORM (non FMLA)

I request to be placed on a Personal Medical leave of absence. Due to FMLA requirements, I am currently not eligible based on one or both of the conditions listed below:

☐ I have not met the one year employment requirement

☐ I have not worked 1,250 hours over the previous 12 months

FMLA requires covered employers to provide up to 12 work weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. **Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months**.

Full Name: _____Employee#:_____ Department:_____

Office Phone #:_____ Home #:_____Email:_____

Requested Leave Start Date: _____ / _____ / _____ Requested Leave End Date: _____ / _____ / _____

REASON FOR LEAVE OF ABSENCE: (Maximum time allowed for personal medical leave is 12 weeks in a rolling 12-month period)

Employee Medical Condition: (Maximum time allowed is 12 work weeks)

___ Medical leave of absence for a serious health condition that makes me unable to work.
(Attach medical certification from your health care provider. See additional provisions in the You and UAB Handbook for Faculty & Staff)

Please check one:

◯ **Illness/Injury** ◯ **Pregnancy**

I understand that I must first use all of my eligible accrued benefit time at the beginning of my leave of absence as a part of my leave of absence. I understand that if I do not return to work after the leave, UAB may recover payments for health insurance made by the University during my leave of absence. I understand that time spent on leave of absence does not count toward completion of the initial probationary period. I understand that failure to return to work on the date stated above as the leave end date or that misrepresentation of facts on this form will jeopardize my reinstatement at the UAB.

Employee Signature: _____ Date: _____/_____/_____

SUPERVISOR/MANAGER/DEPARTMENT HEAD: Complete this section

Acknowledgement of Request:

Department Supervisor: _____ Date: _____/_____/_____

Supervisor Phone Number: _____

Employee has accrued time to be paid through: Date: _____/_____/_____

Send completed form to HR Records, AB254 or email to Leave@uab.edu