



## Eastern Washington University Employee Leave Request Form

Employee – Please complete all fields below so that we may contact you if needed:

Employee's Name:	<input type="text"/>	ID #:	<input type="text"/>
Department:	<input type="text"/>	Supervisor:	<input type="text"/>
Work Phone:	<input type="text"/>	Home Phone:	<input type="text"/>
Mailing Address:	<input type="text"/>		
Personal Email:	<input type="text"/>		

Initial to confirm you have notified your supervisor of the need and duration for leave requested below. (Specific medical information does not need to be provided to supervisors)

### Reason for Leave

- Birth of a child / Adoption or Foster Care of child      Due Date or Placement Date: \_\_\_\_\_
- My serious health condition
- Care of an immediate family member with a serious health condition:    Spouse     Child     Parent
- Military exigency due to a family member (spouse, child, or parent) or     Military caregiver leave

### Length or Frequency of Leave

Requested leave start date: \_\_\_\_\_ Anticipated leave end date: \_\_\_\_\_

Will you be absent from work continuously for a period of time?    Yes       No

If **yes**, provide the time frame: From: \_\_\_\_\_ To: \_\_\_\_\_

If your absences will be intermittent, how often do you expect to be absent from work?

\_\_\_\_\_  Hours per  day;  week;  month **OR** \_\_\_\_\_  Days per  week;  month

### Employee Consent to Release Information

Yes I do     No I do not    authorize my health care provider(s) to communicate with EWU Benefit's Office as needed to clarify or authenticate my medical certification for leave purposes. I understand this authorization is limited to this leave request and will expire when the leave is completed or 12 months from the date signed, whichever comes first. I may revoke this authorization at any time in writing, except to the extent it has already been relied upon. I understand that information disclosed may no longer be protected under federal privacy laws once released, and that signing this authorization is voluntary and is not required for treatment, payment, enrollment, or eligibility for benefits.

### Employee Signature

By my signature below, I certify the information I provided is true, accurate and complete. I also understand that I must provide supporting documentation in order for my leave to be processed and approved by Benefits.

Employee Signature	Date Signed

Employees must provide a certification from a qualified health care provider confirming the medical necessity for leave (Health Care Provider Medical Certification is available on the Benefits/HR website or in the Benefits office in Showalter Hall #318) or a statement from the appropriate agency for placement of a child or a copy of the covered military member's active duty orders. Your leave request cannot be approved without these completed forms.

Have questions? Please call the Benefits Office at 509-359-4300. Note: Employees are responsible for entering their timesheet into Banner for every pay period they are on leave. Employees should check with the Benefits Office regarding how many hours will need to be used in order to maintain their benefits.