LE MOYNE
SPIRIT. INQUIRY. LEADERSHIP. JESUIT.

Office of Human Resources
1419 Salt Springs Road
Phone: 315.445.4155
Fax: 315.445.6023

Leave of Absence Request Form

Employee's Name: _____

Position: _____ Dept: _____

Supervisor: _____

Contact Email or Number while on leave: _____

Type of Leave Requested (choose all that apply):

☐ Unpaid Leave of Absence ☐ Medical/Disability/Maternity Leave ☐ Military ☐ Other

☐ FMLA (unpaid leave; must meet requirements; maximum of 12 weeks) * Certification of Health Care Provider for Employee or Family Member's Serious Health Condition form is required (http://www.dol.gov/whd/fmla/) or a doctor's note

Anticipated start date: _____ Anticipated duration: _____

Reason for Leave: _____

Will you be using vacation time? ☐ Yes; _____ (# of days) ☐ No

☐ **Medical/Disability/Maternity Leave: Salary & Benefits Continuation:** While on a medical leave your salary will continue at 100% and benefits will remain the same. Is disability a work-related injury: ☐ Yes ☐ No

I have read the instructions above. I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled; and that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete. Please have your physician complete the **Physician Statement.**

☐ **Unpaid leave of absence:** I understand the granting of such a leave is dependent upon the work load of the department to which I am assigned and the approval of my department supervisor. During an unpaid leave of absence benefits will continue and you will be directed billed for premiums (unless arrangements are made ahead of time for Payroll to process double deductions of premiums).

Employee's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Supervisor Comments (if applicable): _____

_____

_____

HR's Signature: _____ Date: _____

Last Day Worked: _____ ☐ Change in Status Form

Return to work date: _____ ☐ WAGS updated

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Physician's Statement
Proof of Claim for Disability Benefits

Patient's Name: _____

Diagnosis/Analysis: _____

_____

Date that claimant will be unable to work because of this disability: _____

Date that claimant will be able to return to work (anticipated): _____

Remarks (Attach additional sheet if necessary): _____

_____

_____

I affirm that I am a: _____ Licensed in the State of: _____

License #: _____

Physician's Signature: _____ Date: _____

Physician's Name (Please print): _____ Phone #: _____

Office Address:

_____

_____

Please send the completed form to Le Moyne College Human Resources Office:

Contact:	Amy Zubieta, Assistant Director for Human Resources
Email:	zubietak@lemoyne.edu
Phone:	315-445-4156
Fax:	315-445-6023

Mail: Le Moyne College
Human Resources
1419 Salt Springs Road
Syracuse, NY 13214