

### Employee Information

Name: \_\_\_\_\_ Date of Hire: \_\_\_\_\_  
Job Status: Faculty Cell/Home Phone: \_\_\_\_\_  
Department: \_\_\_\_\_ Mail Stop: \_\_\_\_\_  
Supervisor: \_\_\_\_\_ Campus Extension: 6- \_\_\_\_\_  
Preferred email address while on leave: \_\_\_\_\_

### Leave Information

Date leave is scheduled to begin: \_\_\_\_\_ Date you expect to return to work: \_\_\_\_\_

**Type of Leave:** Parental Leave (birth/adoption/placement) Approx. due date \_\_\_\_\_

Employee illness Family member illness Intermittent Leave? Yes No

Military-Qualifying Exigency Military-Service member *If intermittent leave, please attach planned schedule of days or reduced leave schedule*

### Payment of Benefits (for unpaid leaves of absence only)

**Please complete the following if you are taking an unpaid leave or should your leave transition from paid to unpaid:**

During the period of your unpaid leave, you have the following options for payment of your portion of premiums to the University for: medical, dental and/or vision insurance coverage as well as other benefits:

Option #1: I will provide Brandeis University a monthly check for payment of insurance premiums, for which I am responsible for, prior to the 1st day of each month of my unpaid leave of absence.

Option #2: I authorize Brandeis University to withhold any unpaid insurance premiums, for which I am responsible, from my paycheck upon returning from my unpaid leave of absence.

### Your Signature

I have read and understand the Brandeis University FMLA Policy for Faculty. A Certificate of Health Care Provider form must be completed in order to be considered for approval. If necessary, I have elected the above option for payment of my benefits. It is my responsibility to reimburse the University its portion of premiums for health, dental, and/or vision insurance, should I elect to accept other employment or do not return to Brandeis due to reasons under my control. If the leave is necessary due to my illness, I must also submit a completed and signed Fitness for Duty Form in order to return to work.

I certify that this application for FMLA Leave is true and accurate.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date