FAMILY MEDICAL LEAVE EMPLOYEE PAY ELECTION FORM

SECTION ONE: (Please Print)

Employee Name: _____ T-_____

Office Number: _____ Mobile Phone Number: _____

Union Designation: _____ Personal Email Address: _____

SECTION TWO:

FMLA Leave Start Date: _____ Anticipated Return Date: _____

Intermittent Leave Dates: _____

Reduced Schedule: _____

☐ I acknowledge that I must continue to pay my share of health insurance premiums during my leave. If necessary, I will make arrangements with Human Resources for payment.

☐ I acknowledge that FMLA time is unpaid. Employees must use accruals for pay to continue when utilizing FMLA leave in accordance with the University's FMLA policy.

SECTION THREE:

FMLA ONLY DESIGNATION

Faculty are ineligible for Sick, Vacation, and Personal Business Accruals

Do You want to keep 5 Days of SICK in your bank? YES_____ NO _____

Do You want to use Accruals to get to 100% PAY? YES _____ NO _____

IF YES, Which Accurals? SICK_____ VACATION_____ PERSONAL BUSINESS_____ ANY/ALL____

SECTION FOUR:

EMPLOYEE SIGNATURE: _____ DATE: _____

SUPERVISOR NAME: _____ SUPERVISOR SIGNATURE: _____

SUBMIT FORM

FAX: 313-993-1015 OR EMAIL: benefits@udmercy.edu