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