Extended Leave of Absence Request Form

Except in emergency situations, this form is to be completed PRIOR to the use of extended leave.
NOTE: attach a projected attendance sheet for leave requests longer than one month.

Employee Section:

Name _____ Home or Mobile Phone Number _____

Email _____

Type of leave requested:
Check more than one if taking both paid and unpaid time.

- ☐ Paid Medical (sick leave)
- ☐ Unpaid Medical Leave
- ☐ Unpaid Family Leave
- ☐ Unpaid Personal Leave

Last day present at work _____ First unpaid day, if applicable: _____ Estimated return date: _____

REQUIRED, if requesting use of sick time:

Number of days requested: _____ Number of days available: _____

If the request is due to an accident/injury, was the accident/injury at work or work-related? ☐ Yes** ☐ No

**If you answered "yes" to the above question, please call 217-524-6876 to request Workers' Compensation information and/or forms.

Employee Acknowledgement, Approval to Release Medical Records, and Signature:

I acknowledge and understand that if I am on unpaid leave that I may be billed for insurance premiums by Central Management Services. I understand that non-payment of billed insurance premiums may result in payroll deductions and/or termination of my insurance coverage. I also understand that paid or unpaid leaves of absence which qualify as leave provided under the Family and Medical Leave Act will be counted toward my annual entitlement of FMLA leave. I acknowledge that the FMLA provisions have been provided to me in the *Administrative Regulations*.

I authorize my health care provider listed below to release the information requested in order to support this leave of absence.

Employee Signature_____ Date _____

Physician's Section:

This section must be completed by the attending physician OR a physician's statement **must** be attached for medical leave. If a physician's statement is provided, it **must** include: (1) the date the leave will begin, (2) an expected date of return, and (3) the general nature of the disability.

This is to certify_____ is under my professional care. The above-named employee is: *(check one)*

- ☐ unable to perform his/her required job duties due to the condition listed below.
- ☐ the primary caregiver for my patient with the condition listed below.

Beginning leave date:_____ Estimated return date:_____*

General Nature of Disability or Illness/Physician Comments:_____

_____

Physician's Name_____ Phone # _____

Address _____

Signature_____ Date _____

**If the return date changes from the original approved request, an updated physician's statement must be submitted.*

Employee Name: _____ Request Date: _____

Except in emergency situations, this form is to be completed PRIOR to the use of extended leave. Please attach a projected attendance sheet for leave requests longer than one month. Unpaid leave should be reported immediately to Court Reporting Services by phone or e-mail even if this form is not yet complete.

Administrative Authority Section:

I have reviewed this leave request and have verified the paid leave days requested and available as accurate. This leave is either approved or denied by me as the administrative authority for court reporters in this circuit.

☐ Approved ☐ Denied*

Chief Judge or Designee: _____ Date _____

Printed Name: _____

Title: _____

*Reason for denial _____

Return approved leave forms to Court Reporting Services by email to dustie@ilcrs.com and upload a copy to the employee's leave request on WebHR along with a projected attendance when required.

Leave Definitions:

Paid Medical Leave - Use of sick leave for an extended period of three or more consecutive days. Paid medical leaves require a physician's statement indicating the nature and extent of the disability. May also be considered FMLA leave. May be used for the employee's own illness/injury or for an immediate family member illness.

Unpaid Family Leave - Unpaid leave provided for under the provisions of the Family & Medical Leave Act when taking the leave to care for a family member or other defined reasons which are not for the employee's own illness/injury. A statement from the family member's physician should be used/attached. The state's portion of insurance premiums will continue to be paid during this time, if applicable. The employee will be billed for the employee portion. Limited to 12 weeks from the last day present at work.

Unpaid Medical Leave - After an employee has used all paid leave benefits and unpaid FMLA leave (if applicable), an employee may be approved for unpaid medical leave (also known as non-occupational leave). During an unpaid medical leave, the employee may apply for non-occupational disability benefits which are provided by the State Retirement System. To inquire about benefits which may be available, contact the State Retirement System directly at (217) 785-7444. During approved unpaid medical leave, the state's portion of the insurance premiums will continue to be paid. Employees will be billed for the employee portion.

Unpaid Personal Leave - Refers to any leave requested for a personal reason which does not fall under the leave provisions of the Family and Medical Leave Act or unpaid medical leave above. The employee will be required to pay both the state's and the employee's portion of insurance premiums. Employees may also opt-out of insurance during this time.

Occupational Leave - Refers to any work-related injury or disease. Work-related injuries **must** be reported to the Office of the Comptroller immediately, including injuries such as carpal tunnel syndrome. This form must be submitted for paid or unpaid medical leave of absence if a worker's compensation (temporary total disability) status has not yet been determined.