

Extended Leave of Absence Request Form

Except in emergency situations, this form is to be completed PRIOR to the use of extended leave.

Note: Please attach a projected attendance sheet for leave requests longer than two weeks.

Employee Section:

Name: _____

Cell Phone Number: _____

Email: _____

Circuit: _____

SECTION 1: FMLA (JOB PROTECTION)

- ☐ I have been employed under Court Reporting Services for 12 months or longer.
- ☐ I have **not** used any FMLA benefits within the past 12 rolling months (or)
- ☐ I **have** used FMLA benefits within the past 12 rolling months.*

*Dates of previous FMLA leave: _____

The Family and Medical Leave Act of 1993 (FMLA) provides eligible employees up to 12 weeks of unpaid leave in a rolling 12-month period. "Eligible employees" are those who have worked for the State of Illinois for at least 12 months prior to the time of the leave request (not necessarily successively), and who have worked for at least 1,250 hours in a position within Court Reporting Services during the previous 12-month period. FMLA is not a paid leave benefit unless the employee utilizes accrued leave time in conjunction with FMLA leave.

SECTION 2: LEAVE TYPE

Check more than one if taking both paid and unpaid time or intermittent leave.

- ☐ Paid Family Leave (Employee's sick leave)
- ☐ Paid Family Leave (To care for a family member)
- ☐ Unpaid Medical Leave (Individual's Medical Leave)
- ☐ Unpaid Family Leave (To care for a family member)
- ☐ Unpaid Personal Leave
- ☐ Maternity/Paternity Leave (50 days) (Attach pregnancy cert.)
- ☐ Sick Bank Leave (30 days)
- ☐ The above selected leave is INTERMITTENT leave.

SECTION 3: LEAVE DATES

Last date present at work: _____

First date of UNPAID leave: _____ N/A

Estimated return date: _____

If this request is due to an accident or injury, was the accident or injury at work or work-related?

☐ YES* ☐ NO

*If you answered "yes" to the above question, please call Gallagher Bassett Services, Inc. Injury Reporting Hotline: 1-833-732-5567 to file a report.

SECTION 4: 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: _____

SECTION 5: 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 their 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's Comments: _____

Physician's Name: _____

Phone #: _____

Address: _____

Signature: _____

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

SECTION 6: Administrative Authority Review:

Employee Name: _____ **Request Date:** _____

Except in emergency situations, this form is to be completed *PRIOR* to the use of extended leave. Please complete the projected attendance sheet for requests longer than two weeks. Unpaid leave should be reported immediately to Court Reporting Services even if this form is not yet complete.

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

☐ Approved

☐ Denied*

Administrative Authority Signature: _____ Date: _____

Printed Name: _____ Title: _____

*Reason for denial: _____

Return approved leave forms to Court Reporting Services by email to Brooklyn@ilcrs.com and upload a copy to the employee's leave request on WebHR.

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.

Intermittent Leave – Use of paid or unpaid leave that is sporadic or on an as-needed basis, as instructed by a physician.