MEDICAL LEAVE NOTIFICATION FORM

Northeastern State University

Name _____ SSN _____

Dept/Div/Coll _____ Job Title _____ Job Code_____

Pos # _____ Acct # _____ Hire Date _____

Work shift (regularly scheduled working **days/hours** - staff employees only) _____

Medical Leave Begins _____	**Anticipated Return Date _____**
Worker's Comp Leave ☐ Yes ☐ No	**FMLA Leave ☐ Yes ☐ No**
Leave Election:	**Start Date _____**
☐ 3-day wait ☐ 3-hour option	**End Date _____**
☐ No earned leave authorized	
_____ _____	_____ _____
Account Sponsor Date	**Authorized Human Resources Signature Date**

Double-border boxes are for Human Resources and Payroll Use ONLY

Earned leave (in order of use) - use ML Verification Form to determine the date for removal from payroll:

_____ hours Personal Leave _____ hours Vacation _____***TOTAL Available Leave***

Removal from payroll: _____ _____ hours Comp Time

Return from Leave _____ (Date) Limitations (if any) _____

_____ _____ ***Attach Medical Release and forward to HR.***

Account Sponsor **Date**

_____ _____ _____ _____

Payroll Supervisor **Date** **Authorized Human Resources Signature** **Date**

☐ Medical Release Received ☐ Time entered into system

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