Family Medical Leave Act Request Form

1

Employee Name:_____ Employee ID:_____

Department/Title:_____ Interoffice Address:_____

2

I am requesting a leave of absence for the reason so designated and understand that leave for medical reasons cannot exceed twelve weeks in any 12-month period. It is my intention to return to work at the end of the leave period.

Requested Leave Dates

Leave Begin Date: Return to Work Date:

3

Leave Reason: Please check one that applies

☐ Leave for my own serious health condition (briefly describe).*****

☐ Leave to care for a family member with a serious health condition. *Specify the family member's name and relationship to you.

☐ Intermittent leave/reduce schedule due to a serious health condition – own or family member (briefly describe).*

☐ Leave for the birth of a child. ******Leave days may not be requested prior to expected date of birth.***
Baby's Full Name:_____ Expected Birth Date:_____

☐ Leave for the adoption of a child.
Baby's Full Name:_____ Date of Birth:_____

☐ Other* (Please Explain)

4

*****A Certification of Physician or Practitioner form (available in the Employee Services Office) must be completed, and submitted to Employee Services, for leave due to a serious health condition of the employee or the employee's spouse, child or parent. The employee is required to notify Employee Services thirty (30) days in advance when the leave is foreseeable. When unforeseen events require FMLA leave, employee must give notice as soon as possible, preferably within one or two working days.

I understand that I will be reinstated to my same position, or an equivalent position, with equivalent pay, benefits and other employment terms and conditions.

I also understand that failure to return from the approved Family and Medical Leave within the agreed upon timeframe may constitute a voluntary termination.

I have read the Family and Medical Leave and Sick Leave policies (in Employee Handbook) and the other appropriate policy(ies) specific to my absence and am aware of my responsibilities. FMLA approval does not guarantee payment for missed work.

Employee Signature:_____ Request Date:_____

Each department supervisor must sign:

Primary Supervisor Signature:_____ Date:_____

Secondary Supervisor Signature:_____ Date:_____

Return signed form to Employee Services, AE-9

Authorization (to be completed by Employee Services only)

☐ **FMLA leave approved**
☐ **Leave approved - does not qualify for FMLA**
☐ **Leave not approved**
☐ **Certification required - authorization pending**
☐ **Leave approved** ☐ **Leave not approved**

Hire Date:_____ >12 mo seniority?_____
Worked >1250 hrs in last 12 mo?_____
Used FMLA in previous 12 mo?_____
Requesting > 12 weeks?_____

Employee Services Representative:_____ Date:_____

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