



Family and Medical Leave Request Form

Date: _____

Employee: _____

Job Title: _____

Supervisor: _____

Last four digits of SS number: _____

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to up to 12 weeks of unpaid, job protected leave for certain family and medical reasons. Submit this request form to your supervisor at least 30 days before the leave is to commence, when practical. When submission of the request 30 days in advance is not practical, submit the request as early as is practical. The employer reserves the right to deny or postpone leave for failure to give appropriate notice when such denial/postponement would be permitted under federal or state law.

ELIGIBILITY – circle answers

1. Counting any periods of time that you worked for the University (whether they were consecutive or not), have you worked for the University for a total of 12 months or more?

YES NO

2. During the past 12 months, have you worked at least 1,250 hours? (approximately eight months of 40 hour weeks or one year of 25 hour weeks)?

YES NO

3. Have you previously received medical or family leave?

YES NO

If yes provide information below:

Dates of leave

From _____ to _____

Purpose of Leave:

4. Have you taken any intermittent leave?

YES NO

Have you taken time off from scheduled hours?

YES NO

If yes provide details:

REASONS FOR REQUESTING LEAVE:

Leave must be granted for any of the following reasons:

- For a serious health condition that makes it unable for you to perform your job;
- To care for your child, spouse, or parent who has a serious health condition; or
- To care for your child after birth, or for placement after adoption or foster care.

I am requesting leave for the following qualified reason:

Personal serious health condition _____

Serious health condition of:

Spouse _____

Child _____

Parent _____

Birth of a child

Expected delivery date: _____

Adoption or placement of a child for foster care

Child's name: _____

Scheduled date of adoption or placement: _____

DATES OF LEAVE REQUESTED:

I request leave from _____ to _____.

If you are requesting intermittent leave, please provide/attach a schedule of you intended leave time.

Total number of days requested? _____

EMPLOYEE STATEMENT:

I agree to return to work on _____. If circumstances change and I am not able to return to work on that date, I agree to inform my supervisor and the office of Human Resources.

I understand that FMLA is an unpaid leave and that the University will continue to cover the University portion of my benefits. If I have premiums/deductions it is my responsibility to make arrangements to pay those premiums should I go into non-paid status.

Signature: _____ Date: _____