



**Office of Human Resources
Family or Medical Leave
Request Form**

INSTRUCTIONS FOR THE EMPLOYEE

- Complete the form and submit to HR.
- You will be notified in writing as to whether the leave is approved or not.

EMPLOYEE INFORMATION

Employee Name: _____
 Title: _____
 Department: _____

TYPE OF LEAVE

I hereby request the following type of leave:

Family Leave Anticipated date of birth or placement: _____
 Birth of my son or daughter
 Placement of a child with me for adoption foster care

Family leave to care for a spouse, son, daughter, or parent with a serious health condition
 Family member's full name: _____
 Relationship to you: Spouse Parent Son or Daughter

Medical leave for my own serious health condition (specify): _____

AMOUNT OF LEAVE

I request that the leave be granted for the following period of time:
 Beginning on (date): _____ Ending on (date): _____

I further request that the leave be granted for the following reduced or intermittent leave schedule:

I would like to substitute the following paid leave time, if applicable, during my family or medical leave

Sick Days	Vacation Days	** Short-Term Disability

*Please Note: Union employees - available sick time must be used before taking unpaid time. Employee may choose to use vacation time at his or her discretion. ** Please consult with HR regarding eligibility of short-term disability*

EMPLOYEE CERTIFICATION AND SIGNATURE

I hereby certify that the information given above is true and correct to the best of my knowledge. I agree to return to work on _____. If circumstances change such that I will not be able to return to work on that date, I agree to inform Human Resources and to submit a written request for an extension. I understand that my benefits will continue during my leave and that I will arrange to pay my share of applicable premiums.

Signature: _____ Date: _____

My supervisor is aware of this request as indicated by the signature below
 Supervisor: _____ Date: _____

HR USE ONLY

MAINTAIN THIS FORM IN A FMLA CONFIDENTIAL FILE

Leave Approved Denied Expected Return Date _____

Insurance premiums to be paid as follows:
 Previous FML in past 12 months Cert. of Health Care Provider Required
 HR Signature: _____ Date: _____