# 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 amount (days or hours) paid leave time, if applicable, during my family or medical leave

| **PTO/Vacation** | **** Short-Term Disability** | **Other** _____ |
|---|---|---|
| | | |

***** 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:**