

FMLA Request for Leave Form

Employee Information:		
Name:	Person Number:	Date:
Position:	Department:	
Campus Affiliation: <input type="checkbox"/> RF <input type="checkbox"/> State <input type="checkbox"/> UBF		
Hire Date:	Start Date of Leave:	End date of requested leave:
Reason for leave [check the reason(s) that apply below]:		
<input type="checkbox"/> Birth of child <input type="checkbox"/> Adoption of child <input type="checkbox"/> Care for parent, <input type="checkbox"/> child or <input type="checkbox"/> spouse with a serious health condition <input type="checkbox"/> My own serious health condition that prohibits me from performing the essential functions of my position <input type="checkbox"/> Military Family Caregiver Leave <input type="checkbox"/> Military Qualifying Exigency Leave		
Have you taken a leave of absence under this policy during the preceding 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, how many workweeks (or portions thereof) have you taken? _____		
Are you requesting intermittent leave or a reduced schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Acknowledgment:		
I understand that University Human Resources will evaluate my request for Family Medical Leave and notify me whether my request has been approved or denied.		
I understand that if eligible for FMLA, I will need to provide the necessary certification forms to Human Resources by the requested dates.		
<input type="checkbox"/> Medical certification is attached. <input type="checkbox"/> Medical certification will be provided to Human Resources within 15 days of receiving notice of eligibility.		
I understand that where allowed by federal and state law, and/ or University policy, workers' compensation and disability leaves will run concurrently with FMLA leave. Also, I understand that this leave will be counted against my annual family medical leave entitlement.		
I understand that I am responsible for immediately notifying Human Resources of any changes in the requested leave period.		
I have read the University's Family and Medical Leave procedure, and I agree to abide by its requirements. I understand that falsification of information may lead to disciplinary action.		
Employee Signature:		Date:
Approvals:		
Human Resources:		Received: