FAYETTEVILLE STATE UNIVERSITY

Office of Human Resources

FAMILY MEDICAL LEAVE REQUEST FORM

NOTICE: The employee shall give 30 days' notice to the supervisor of the intention to take leave under the FMLA Policy unless the leave is a medical emergency. In case of emergency, submit form as soon as practical. **In addition to the Leave Request Form a Medical Certification must be completed by the treating physician and forwarded to Human Resources.**

BENEIFTS PROTECTION: You have a right under the FMLA for up to 12 weeks of paid or unpaid leave in a 12-month period. Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you must be reinstated to the same or equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or (2) other circumstances beyond your control, you may be required to reimburse the University for the share of health insurance premiums paid on your behalf during your FMLA leave.

Employee Information (To Be Completed by the employee and forwarded to supervisor)

Name:_____ Banner Number _____

Home Address:_____ City_____ State_____ Zip Code _____

New FMLA Request ☐ Existing Continuing Request ☐ Military Caregiver Leave Request ☐

Leave Options: Intermittent ☐ Consecutive ☐ Reduced work schedule, ☐

Is this leave being requested to care for child ☐ spouse ☐, parent ☐ , or self ☐

If so, how much time is requested _____

Leave to begin Estimated end date

Do you wish to charge: sick ☐ vacation ☐ other Leave ☐ without pay ☐

I_____ authorize and consent for the appropriate Human Resources representative to contact the health care provider for purposes of clarification and authenticity of the medical certification.

Supervisors: Please sign below as acknowledgement and receipt of employee's request for Family Medical Leave.

Print:_____ Title: _____

Signature:_____ Date: _____

To be completed by Human Resources

Does employee have 12 months of cumulative service? Yes_____or No_____
Is employee working Full-time permanent_____Part-time permanent (half time or more) _____
Temporary (less than half time) _____
Date of Hire_____

Has employee been in pay status at least 1250 hours during the previous 12 months Yes_____or No ____

Month	Year	Hours worked
January		
February		
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		

Total hours: _____

Indicate which criteria meets the Serious Heath Condition:

_____

_____

Leave Balances

Bonus:_____Comp:_____Sick:_____Vacation:_____Other: _____

Human Resources Representative

Approved:_____Denied:_____If denied give reason_____

_____

Signature:_____Date:_____