Family and Medical Leave (FMLA) Request

Eligible Employee must have worked for the employer for a total of 12 months or at least 1,250 hours over the previous 12 months.

Name: _____ A-Number _____

Address: _____ City:_____ Zip:_____

Date of Request: _____ Home/Mobile Phone: ( )_____

Department: _____ Work Location: _____

Date of Hire: _____ Full-Time ___ Part-Time ___ Last Day Worked:_____

Start Date of Anticipated Leave _____ Expected Date of Return _____

If Intermittent Leave, Indicate Schedule and Length of Leave: _____

Reason for FMLA Leave:

☐ My personal serious health condition

☐ Birth of my child ☐ Adoption of a child by me

☐ Placement by the state of a child with me for foster care

☐ Serious health condition of my child ☐ Serious health condition of my parent

☐ Serious health condition of my spouse

If request to leave is to care for a seriously ill family member, indicate family member's name and their relationship to you:

Family Member's Name: _____ Relationship: _____

Comment:

_____

_____

_____ _____

Signature of Employee Date

_____ _____

Vice Chancellor/Campus President Date

_____ _____

Human Resources Date

EMPLOYEE: WHEN COMPLETED, DELIVER REQUEST FORM AND MEDICAL CERTIFICATION TO THE DEPARTMENTOF HUMAN RESOURCES, CENTRAL ADMINISTRATION BUILDING, 2ND FLOOR.