EMPLOYEE
REQUEST FOR FMLA LEAVE

**This form should be filled out and submitted to Human Resources at least thirty (30) days in advance of foreseen leave; otherwise as soon as medical issue is known.

Employee Name: ____

Position: ____

I hereby request FMLA leave from ___________________ to ___________________ for (check one):

A. The birth of a child, or placement of a child with you for adoption or foster care.

B. Your own serious health condition.

C. To care for a spouse, child, or parent due to his/her serious health condition.

D. A qualifying exigency arising out of the fact that your spouse, child, or parent is on covered active duty or call to covered active duty status with the Armed Forces.

E. You are the spouse, child, parent, or next of kin of a covered service member with a serious injury or illness.

Does your spouse also work for the College? Yes No

Would an intermittent or reduced leave schedule meet your needs? Yes No
If yes, specify a schedule that would meet your needs:

____

Note: The Certification of Health Care Provider form will be provided to you from Human Resources. This form is required to be completed by both the employee and physician and returned to Human Resources in a timely manner. This form can be completed prior to or at the start of your leave.

I understand that a failure to return to work at the end of my FMLA leave may be treated as a resignation unless a written request is submitted to the Board of Trustees and they have authorized any additional unpaid leave time.

Employee Signature: ____ Date: ____________________

Human Resources Signature: _____________________________________ Date: ___________________