

Request for Family or Medical Leave

PLEASE PRINT



P.O. Box 1189, Hamlet, NC 28345

Request for Family and Medical Leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin. Supporting certification from your health care provider should substantiate 1) the date when leave is to begin, 2) the probable duration, 3) a statement that leave is necessary to care for a child, spouse, or the employee is unable to perform the functions of their position, whichever applies, and 4) any applicable restrictions upon return to work. Please review the FMLA policy in the Faculty and Staff Handbook.

Name _____ Date: ____/____/____

Position Title: _____ Status: FT PT Temp

Hire date: ____/____/____ Length of Service: _____

Have you taken a family or medical leave in the past 12 months? No Yes If yes, number of workdays? _____

I request Family or medical leave for one or more of the following reasons:

- Because of the birth of my child and in order to care for him/her.

Expected date of birth: ____/____/____ Actual date of birth: ____/____/____

Leave to start: ____/____/____ Expected return date: ____/____/____

- Because of the placement of a child with me for adoption or foster child placement ____/____/____

Leave to start: ____/____/____ Expected return date: ____/____/____

- In order to care for my spouse, child, or parent ____/____/____

Leave to start: ____/____/____ Expected return date: ____/____/____

- For a serious health condition that makes me unable to do my job. Describe: _____

Leave to start: ____/____/____ Expected return date: ____/____/____

NOTE: A physicians certification may be required for leave due to a serious health condition.

- For other reasons. Describe: _____

Leave to start: ____/____/____ Expected return date: ____/____/____

- Requested intermittent leave schedule (if applicable; subject to employer's approval) _____

I understand and agree to the following provisions:

- I have worked for my employer at least one year and at least 1,250 hours in the previous 12 months.
- If I fail to return to work after the leave for reasons other than the continuation, recurrence or onset of a serious health condition that would entitle me to Medical Leave or other circumstances beyond my control, and if my employer requires it, I will be financially responsible for the medical insurance premiums the company paid while I was on leave.
- This leave will be unpaid, unless it is company policy to be paid; or in the case of my own disability, payment will occur under a company disability insurance plan, if I am so covered.
- I may be required to exhaust my paid vacation, personal or sick leave as part of my 12 weeks of leave.
- After 12 weeks of leave, if I do not return to work or contact my supervisor or manager on the date intended, it will be considered that I abandoned my job.

Employee Signature: _____ Date: ____/____/____

Leave Approval

For full day leave:

Supervisor Signature: _____ Date: ____/____/____

For intermittent or reduced day leave:

Supervisor Signature: _____ Date: ____/____/____

Personnel Signature: _____ Date: ____/____/____

Notes: _____

Payroll Instructions

With pay from: ____/____/____ to ____/____/____

Without pay from: ____/____/____ to ____/____/____

Comments: _____
