**REQUEST FOR FAMILY/MEDICAL LEAVE**

Employee Name       Date of Request

Department       Position Title

Hire Date

**Description of the Leave Requested**:

I understand that to qualify for this leave, I must submit documentation certifying the leave within **15 days** of taking the leave. I request a Family/Medical Leave for the following reason (check one):

A. To care for an immediate family member because such family member has a serious health condition.

**Check one:**  **CHILD**  **PARENT**  **SPOUSE**  **DOMESTIC PARTNER**

B. For the birth of a child or to care for a newborn within the first year of the child’s birth.

C. The placement of a child for adoption or foster care.

D. Care for an adult child who is incapable of self care. (A child is “incapable of self care” if he/she requires active assistance or supervision to provide daily self care in three or more of the activities of daily living or instrumental activities of daily living, such as caring for grooming and hygiene, bathing, dressing and eating, cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, etc.)

E. My own serious health condition.

F. To assist a child, spouse, or parent who is a member of the Armed Forces, including the National Guard or Reserves with a “qualifying exigency” related to covered active duty or a call of active duty status.

**Check one:**  **CHILD**  **SPOUSE**  **PARENT**

**To be approved under this section, I understand I must submit a certification of qualifying exigency.**

G. To care for a child, spouse, parent or “next of kin” covered service member of the United States Armed Forces who has a serious injury or illness incurred or aggravated in the line of duty while on active duty (up to 26 weeks of leave).

**Check one:**  **CHILD**  **SPOUSE**  **PARENT**  **NEXT OF KIN**

**To be approved under this section, I understand I must submit a certification from the Department of Defense or Department of Veteran Affairs.**

**Method of Leave Requested:**

A. Consecutive Leave

B. Intermittent or Reduced Leave Schedule (Specify schedule below)

**Duration of Leave Requested:**

Date Leave is to Begin:       Date Leave is to End:

**Information Regarding Return Rights:**

For Faculty Employees:

Faculty employees may be granted up to a one year of unpaid leave of absence for home responsibilities as described by contract (see Article 8.1.). Faculty employees may also be granted paid leave for a variety of reasons as described in the contract (see Article 8.2.). A faculty employee will be returned to his/her current position once the leave of absence is complete. Should a leave of absence exceed any these time frames, the employee may be terminated should they not be granted or be eligible to take any additional leave time.

For All Other Employees:

If the duration of a family/medical leave (total of paid and unpaid time) does not exceed 12 weeks (or 26 weeks to care for an injured service member), or, if the leave is for pregnancy disability (which can last up to 16 weeks), the employee will be returned to the same or equivalent position. Should a leave of absence exceed these time frames, the employee may be terminated should they not be granted or be eligible to take any additional leave time.

**Signature**:

|  |  |
| --- | --- |
| Employee: | Date: |

**Signature of Supervisor Acknowledgment**:

|  |  |
| --- | --- |
|  | Date: |