



Family Medical Leave Act Request Form

1

Employee Name _____ Employee ID _____
(Last) (First) (MI)

Department _____ Department ID _____

2

I am requesting a leave of absence for the reason so designated and understand that the leave cannot exceed twelve weeks. It is my intention to return to work at the end of the leave period.

Requested Leave Dates

Leave Begin Date	<input type="text"/> <input type="text"/> <input type="text"/>	Leave End Date	<input type="text"/> <input type="text"/> <input type="text"/>
	Month Day Year		Month Day Year

Please check one in each category:

Leave Reason

- Birth or Adoption
- Care of Child
- Care of Parent
- Care of Spouse
- Employee Illness

Leave Type

- Continuous
- Intermittent
- Reduced Schedule

Time Requested

-
- Days
 - Hours
 - Weeks

I understand that I will be reinstated to my same position, or an equivalent position, with equivalent pay, benefits and other employment terms and conditions.

I also understand that failure to return from the approved Family and Medical Leave within the agreed upon timeframe may constitute a voluntary termination.

I have read the Family and Medical Leave policy and the other appropriate policy(ies) specific to my absence and am aware of my responsibilities.

LEAVE WILL BE PAID ONLY IF EMPLOYEE HAS SUFFICIENT AND APPROPRIATE ACCRUALS TO COVER PART OR ALL OF THE ABSENCE.

Employee Signature ▶ _____ **Request Date** ▶ _____

Supervisor/Department Head ▶ _____ **Date** ▶ _____

Benefits Manager ▶ _____ **Date** ▶ _____