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| Fayetteville Technicial Community College  |
| **REQUEST FOR FAMILY MEDICAL LEAVE** |
| Employee Name: |       | Dept. |       | Datatel # |       |
| Date of Employment: |       | **Note**: Must have been employed for a year (full- or part-time) and have worked at least 1250 hours in the previous 12 months.  |
| Beginning Date of Leave: |       | Ending Date of Leave: |       |
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| A. | Reason for requesting FMLA: (Check one) |
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|  | 1. | [ ]  | The birth of a child, or the placement of a child with me for adoption or foster care. (12 weeks) |
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|  | 2. | [ ]  | A serious health condition that makes me unable to perform the essential functions of my job. (12 weeks) |
|  |  |  |  |
|  | 3. | [ ]  | A serious health condition for which I am needed to provide care for my: (12 weeks) |
|  |  |  | [ ]  | Spouse | [ ]  | Child | [ ]  | Parent(s)       |
|  |  |  |  |  |  |  |  |  |
|  | 4. | [ ]  | Qualifying Exigency Leave. (12 weeks) |
|  |  |  |  |
|  | 5. | [ ]  | Military Caregiver Leave. (26 weeks) |
| B. | Please provide medical certification completed by the appropriate medical personnel by using: (Check one)1. [ ]  Certification of Health Care Provider - Form WH-380E (Employee) or WH-380F (Family member).2. [ ]  Doctor's note reflecting the dates you will be under a doctor's care, the medical facts, restrictions (if any), and the return to work date.   |
| * I have been informed that I am entitled up to 12 weeks of FMLA leave in a 12 month period (26 weeks if Military Caregiver). My health benefits must be maintained during any period of unpaid leave under the same conditions as if I continued to work. (Contact the Benefits Office at 8-8240 to discuss continuation of health benefits while on FMLA).
* I understand that my FMLA condition does not provide absolution for unrelated absences or eliminate my requirement to adhere to attendance, work, or productivity standards.
* I understand that I must notify my supervisor of any absence and specify which absences are related to my FMLA condition in my Timeclock.
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|  | Employee Signature |  | Date |
| * I understand that I must ensure the employee listed above notates all FMLA absences in his/her Timeclock.
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|  |  |  |  |
|  | Supervisor Signature |  | Date |
|  |  |  |  |
|  | Appropriate Vice President |  | Date |
|  |  |  |  |
|  | VP for HR/IE |  | Date |
|  |  |  |  |
|  | President |  | Date |
|  | Attachmentcc: Payroll and Benefits Office  |
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