Employee FMLA Leave Request

(Family/Medical Leave Request Form)

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to take up to 12 or 26 weeks of job-protected leave for certain family and medical reasons. Submit this request form to Human Resources (Founders Hall, Building 1, Room 104) at least 30 days before the leave is to begin, when possible. When 30 days' advance submission of the request form is not possible, submit the request as soon as possible. College of Central Florida reserves the right to deny or postpone leave if you do not give adequate notice when permitted under federal and/or state law.

Employee Information

Please print.

Name: _____ Employee ID #: _____

Department: _____ Job Title: _____

Today's Date: ___ ___ _____ Hire Date: ___ ___ _____ Supervisor: _____

Status: ☐Full-Time ☐Part-Time ☐Temporary

Reason for Requesting Leave

I am requesting family/medical leave for the following reasons: (check all that apply)

☐Birth of my child; to care for my newborn child

☐Placement of a child with me for ☐ adoption ☐ foster care

☐Leave to care for a family member with a serious health condition

Relationship of family member to you: _____

☐My own serious health condition

☐Qualifying exigency because a family member is on or has been called to covered active duty in the Regular Armed Forces (including the National Guard and Reserves) to a foreign country

Relationship of family member to you: _____

☐Leave to care for a family member who is a current member of the Armed Forces (including the National Guard and Reserves) or a covered veteran and who is undergoing medical treatment, recuperation, or therapy, is in outpatient status or on temporary disability retired list for a serious injury or illness

Relationship of family member to you: _____

☐Other (please explain) _____

_____

Duration of Leave

Leave expected to begin: ___ ___ _____ Leave expected to end: ___ ___ _____

If intermittent or reduced-leave schedule is being requested, please explain the proposed leave schedule:

_____

_____

Employee Certification and Signature

I certify that the above information is true and correct to the best of my knowledge:

Employee signature: _____ Date: _____

Supervisor signature: _____ Date: _____

HR Rep Signature: _____ Date: _____

EMPLOYER: This form should be treated as a medical record and must be maintained separately from employee personnel files, in locked cabinets with only designated personnel having access. As an employer, you should retain this original and provide a photocopy of the form to your employee along with the Company Response form within a reasonable period of time.