



# Family Medical Leave Request Form

Last Name	First	M.
Employee ID		Work Phone

Family Medical Leave under University Regulation 04.06.144 may be initiated by the employee, the supervisor, or Human Resources.

Please contact Human Resources (HR) for detailed information relating to benefits provided and eligibility requirements.

## Section I: Employee, Supervisor or HR may complete this section

Supervisor Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

Department: \_\_\_\_\_ Campus (MAU): \_\_\_\_\_

Anticipated Duration of Leave: \_\_\_\_\_ to \_\_\_\_\_  
(may not exceed maximum allowed by law)

Reason for FML:

- The birth or adoption of employee's child
- Placement of child with employee for foster care
- Employee's serious health condition<sup>1</sup> that makes the employee unable to perform the essential functions of his/her job
- Employee is needed to care for an immediate family member<sup>2</sup> with a serious health condition  
Immediate family member name and relationship: \_\_\_\_\_

If child, date of birth: \_\_\_\_\_

Type of FML Requested:

- Continuous Leave
- Intermittent Leave (includes leave taken as a reduced work schedule)

## Section II: To be completed by employee (if available)

I am requesting Family Medical Leave (FML) per UA Regulation 04.06.144. I understand that:

- I must meet eligibility requirements for FML
- FML benefits are limited per federal and state law.
- Certification of Health Care Provider (DOL Form WH-380) is required for my personal serious medical condition or for a family member's serious medical condition and will be submitted directly to HR within 15 days. (DO NOT attach to this application.)
- I need to discuss the status of my benefits with a Human Resource Consultant
- I must exhaust all accrued sick leave, annual leave, and personal holiday, if applicable, prior to beginning leave without pay.
- I may be required to provide periodic recertification of the serious medical condition of myself or my immediate family member.
- Prior to return to work, I will provide HR with a release to return to work if FML is for my serious health condition.
- If approved, this absence will be counted towards my FML entitlement.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
e-mail

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**Section III: To be completed by Supervisor**

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- Acknowledgment of FML Request (where notification is initiated by employee)
- Notice to HR regarding possible FML event (where notification is initiated by supervisor)

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Supervisor Signature

Date

e-mail

**IMPORTANT**

Immediately forward this completed form to Human Resources for approval and notification to employee of status of leave and benefits.

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**Section IV: HR Use Only**

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- Employee's request qualifies as Family Medical Leave under UA Regulation 04.06.144
  - Employee meets eligibility requirements for length of employment or hours worked
    - State    and/or     Federal
  - Event meets criteria for  serious health condition or  parental leave
    - State    and/or     Federal
  - FML benefits have not been previously exhausted during applicable period.
- Employee's request does not qualify as Family Medical Leave under UA Regulation 04.06.144
  - Employee does not meet eligibility requirements for length of employment or hours worked
  - Event does not meet criteria for "serious health condition" or parental leave
  - FML benefits have been previously exhausted
  - Ineligible event : \_\_\_\_\_

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Human Resources Consultant Signature

Date

Copy to: Employee  
Supervisor  
PPA

Original to FML File

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**Section V: Comments and Footnotes**

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- (1) Requests for FML based on the serious health condition of the employee or an immediate family member require a Physician/Practitioner Certification of Health Care.
- (2) Immediate family member is defined in UA Regulation 04.06.144.

Other Notes/Comments/Conditions:

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