REQUEST FOR FAMILY AND MEDICAL LEAVE

FMLA requires employers to provide up to 12 weeks of job-protected leave to eligible employees under any of the conditions stated below. Employees seeking to use FMLA leave are required to provide 30-day advance notice of the need to take leave when the need is foreseeable and such notice is practicable. If leave is foreseeable less than 30 days in advance, the employee must provide notice as soon as practicable – generally, either the same or the next business day. The University reserves the right to deny or postpone leave for failure to give appropriate notice when such denial/postponement would be permitted under federal or state law. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. **Additional information and forms are located in the Employment Services Office, room 160 of the Administration Building.**

1. To be completed by the person requesting the leave. (Please Print Legibly or Type)

Name:	Department:
ID #:	Personal Contact Number:
Home Address:	

2. Dates and amount of leave time requested:

Date leave for medical/FMLA begins:	Anticipated date medical/FMLA ends:

3. Leave requested for the following purpose ☒(mark one):

☐	The birth of my child or placement of a child with me for adoption or foster care.
☐	A serious health condition that makes me unable to perform the essential functions of my position.
☐	A serious health condition affecting my ___ spouse, ___ child, or ___ parent for which I am needed to provide care. (Documentation of the health condition required.)
☐	Because of a qualifying exigency arising out of the fact that my ___ spouse, ___ son or daughter, or ___ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
☐	Because I am the ___ spouse, ___ son or daughter, ___ parent, or ___ next of kin of a covered service member with a serious injury or illness.

If married and requesting (a) leave for birth of placement of a child through adoption or foster care, or (b) to care for your child who is a covered service member, please indicate whether your spouse is also an employee of East Central University: ☐yes ☐no
If '**yes**', provide spouse name and department:

Please Note:

Leave of three (3) consecutive days or more taken for any of the above reasons applies toward the twelve weeks of eligibility for leave provided in the Family & Medical Leave Act (FMLA). FMLA can run concurrently with other types of qualifying leave. FMLA protects employee benefits and job for a minimum of 12 weeks. W**hile on FMLA an employee shall have no expectation of receiving either their monthly salary or a percentage of their monthly salary with an exception to leave time already accrued.**

Upon approval of this request, I accept the conditions of the University's Family and Medical Leave Act Policy.

Employee Signature:____ Date:_________________________

Supervisor Signature:____ Date:_________________________

☐ APPROVED ☐ NOT APPROVED

Vice President Signature:____ Date:_________________________

Retain a copy for departmental records. Send the *original* to the Employment Services Office.