AUGUSTA UNIVERSITY

Family and Medical Leave Act (FMLA) Intermittent Absence Report

To be used only for

APPROVED FMLA INTERMITTENT CALL-INS

IT IS THE RESPONSIBILITY OF THE EMPLOYEE TO FILL OUT FOR EACH ABSENCE YOU STATE IS FMLA COVERED AND TURN IN TO:

Your Supervisor/Manager

This information must be provided within 2 working days following your return to work from an absence, or the absence may not be designated as FMLA.

EMPLOYEE INFORMATION AND CERTIFICATION

Employee's Name: _____

I submitted a certification of the serious health condition to the Benefits and Data Management section of Human Resources on:

_____ myself or _____ my covered family member.

_____ My absence was due to the incapacity of myself or my covered family member.

OR

_____ My absence was due to medical treatment, physical therapy, office visit etc.

Date of absence (called-in):_____

Hours missed on that day: _____

I hereby certify that my absence from work at the above dates and times related to the serious health condition described above, and that the information given above is true and correct to the best of my knowledge. I understand that misrepresentation of the reason for leave or any of the facts supporting the need for leave will result in denial of the leave and could also result in disciplinary action.

_____ _____

Employee Date