AUGUSTA UNIVERSITY

**Human Resources**

# Family and Medical Leave Request

Date _____

**To be completed by employee:**

Employee name _____ Social Security Number _____

Job title _____ Supervisor or Dept. Head _____

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to up to 12 weeks of job-protected leave for certain family and medical reasons. Submit this request form to your supervisor or department head at least 30 days before the leave is to commence, when possible. When submission of the request 30 days in advance is not possible, submit the request as early as is possible. The employer 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.

1. ☐ Yes ☐ No Counting any periods of time you worked for the Augusta University (whether they were consecutive or not), have you worked for Augusta University for a total of 12 months or more? (If "yes," continue to question 2. If "no," stop here. Sign and submit this form to your supervisor or department head.)

2. ☐ Yes ☐ No During the past 12 months, have you worked at least 1,250 hours (approximately eight months of 40-hour weeks or one year of 25-hour weeks)? (If "yes," continue to question 3. If "no," stop here. Sign and submit this form to your supervisor or department head.)

3. ☐ Yes ☐ No Have you previously received medical or family leave?
   If yes, provide information below:

   Dates of leave _____ to _____
   Purpose of leave _____

4. ☐ Yes ☐ No Have you taken any intermittent medical leave?

5. ☐ Yes ☐ No Have you taken time off from scheduled hours?
   If "yes," provide details _____

6. ☐ Yes ☐ No Is your spouse employed by Augusta University?
   If "yes," spouse's name: _____

**Reasons for requesting leave**

Leave must be granted for any of the following reasons:

- For a serious health condition that prevents you from performing the duties of your job;
- To care for your child, spouse, or parent who has a serious health condition; or
- To care for your child after birth, or for placement after adoption or foster care.

I request leave for the following reason:

☐ Personal serious health condition

☐ Serious health condition of: ☐ spouse ☐ child ☐ parent

☐ Birth of a child

☐ Adoption or placement of a child for foster care _____
Scheduled date of adoption or placement

**Dates of leave requested**

I request leave from _____ to _____

I request intermittent leave according to the following schedule:

I request a reduced schedule leave according to the following schedule:

The total number of leave days I request is

**Employee statement**

I agree to return to work on _____. If circumstances change such that I will not be able to return to work on that date, I agree to inform my supervisor by submitting a NOTICE TO MY SUPERVISOR. I understand my benefits will continue during my leave and I must arrange to pay my share of applicable premiums.

Signature _____ Date _____

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**TO BE COMPLETED BY SUPERVISOR OR DEPARTMENT HEAD/DEAN**

Employee or faculty member was hired on _____ S/he started in this department on _____

Employee or faculty member is ☐ Full time ☐ Part time

Current schedule commenced on _____ (If there was an earlier schedule, list below):

Employee has previously requested family or medical leave on _____

Leave taken from _____ to _____ Total time taken _____

Name of supervisor or department head: _____

Date: _____ Telephone #: _____

All completed forms should be submitted to the HR Benefits & Data Management Section and will be maintained in the HR Benefits & Data Management Section.

Prior leave requests confirmed: _____

Leave is ☐ Approved

☐ Denied for the following reason(s)

Request approved /denied by (department): _____ Date:_____