

## REQUEST FOR FAMILY AND MEDICAL LEAVE

Return this form to Business Service Center - Human Resources or Fax (940) 369-5599. Request for Family or Medical Leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin.

<b>EMPLOYEE INFORMATION (To be completed by the employee – Please print)</b>	
<b>Name:</b>	<b>Employee ID#:</b>
<b>Job Title:</b>	<b>Date of Hire:</b>
<b>Home Address:</b>	<b>Department:</b>
<b>Contact #:</b>	<b>Supervisor:</b>
<b>3. Reason for requesting leave. Check one:</b> a. <input type="checkbox"/> Birth of a child b. <input type="checkbox"/> Placement of a son or daughter for adoption/foster care c. <input type="checkbox"/> Care for child, spouse, parent, or legal dependent with a serious health condition (be sure to answer #4 and #5) d. <input type="checkbox"/> Serious health condition which makes me unable to perform the functions of my position	
<b>4. If 3c is checked, please indicate:</b> <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Legal Dependent	
<b>5. If 3c is checked, please provide Name and Address of Family Member:</b>  <hr/>	
<b>6. Effective Date of Leave Request:</b>	<b>7. Date of anticipated return to work:</b>
<b>8. Are you requesting leave on an intermittent or reduced work schedule?</b> <input type="checkbox"/> Yes* <input type="checkbox"/> No <small>*If yes, please provide a completed Certification of Health Care Provider form justifying the necessity for intermittent leave. On a separate sheet give a schedule of when you anticipate you will be unavailable for work.</small>	
<b>9. I understand that I will use all available paid leave. Leave will be paid only if employee has sufficient and appropriate accruals to cover part or all of the absence.</b>	
<b>Employees seeking leave because of Reason 3c or 3d <u>must</u> have a health care provider complete the Certification of Health Care Provider Form and return it to the HR Department <u>within 15 days</u>, or as soon as practicable. Leave may be delayed until a completed Certification of Health Care Provider Form is provided. Employees seeking to return to work after a leave because of Reason 3d, <u>also</u> must complete the Return to Work Medical Certification Form before they will be allowed to resume work. Employees may not be permitted to resume any position until a completed Return to Work Medical Certification Form is provided.</b>	

### EMPLOYEE AGREEMENT

I understand that failure to return from the approved Family and Medical Leave within the agreed upon timeframe may constitute a voluntary termination. I have read the Family and Medical Leave policy and am aware of my responsibilities that I will need to provide necessary medical documentation for any period of FMLA requested and that I will need to notify my supervisor and Human Resources immediately if any of the information above should change. I certify that the information above is accurate. I understand that if any of my leave is unpaid as part of my Family Leave, I will be responsible for contacting the Business Service Center Human Resources Benefits Section at (940) 369-5500 for information on payment of my share of the premiums

I understand that while on FMLA leave I will contact the Human Resources Department after I have been on leave for 30 calendar days and at the end of each 30-day period afterwards.

<b>Employee Signature:</b>	<b>Date:</b>
<b>Supervisor's Signature:</b>	<b>Date:</b>