

FMLA/ PARENTAL LEAVE REQUEST FORM

Date:		Z#	
Employee Name:		Timekeeper:	
Manager/Supervisor:		Employee type: AMP, SP, OPS, or Faculty	
Please provide your preferred method for correspondence which may occur during your leave: email or complete home address:			

The requested leave of absence is due to the following FMLA qualifying event:

- The birth of my child
- The placement of a child with me for adoption or foster care *
- A serious health condition that makes the employee unable to perform the functions of their job
- A serious health condition affecting my: spouse child** parent *In loco parentis*
- Military Caregiver spouse child** parent Next of Kin
- Military Exigency spouse child** parent Next of Kin
- Parental Leave* (Parental Leave may run concurrently with FMLA)

If married and request leave for birth/adoption or care of child, please indicate whether your spouse is also an employee of FAU: Yes or No

If 'Yes', provide spouse's full name: _____

*Provide court documentation in lieu of Certificate of Healthcare Provider

**Son or daughter means a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis, who is either under age 18, or age 18 or older and "incapable of self-care because of a mental or physical disability" at the time that FMLA leave is to commence.

Start date or anticipated start date: _____ End date or anticipated end date: _____
mm/dd/yyyy mm/dd/yyyy

I request the leave to be:

- Continuous** – absence that is three days or longer in a single occurrence
- Intermittent** – absence has periodic occurrences with time worked between absences:

I understand by submitting a request for FMLA-designated leave I agree that:

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- Medical certification from a physician or other qualified healthcare provider (using the appropriate Certification of Healthcare Provider form) will be required for leave due to my serious health condition or the serious health condition of my spouse, child, or parent.
- I will be required to provide a Release to Return to Work form upon return from leave if it is for my own serious health condition.
- If the leave is to be with pay or intermittent leave, it is my responsibility to communicate with my supervisor and/or timekeeper to request and/or verify the type and number of hours of paid leave to be used.
- If the anticipated end date of my leave changes, it is my responsibility to communicate with my supervisor and Human Resources to request approval of the change.
- I am responsible for continuing payment of my employee share of insurance premiums.
- I understand my treating healthcare provider may be contacted to clarify or authenticate my FMLA certification.
- Re-certification may be required every 30 days, unless a specific period of time is designated in the initial certification (re- certification may be requested after the period elapses).
- In order to take service-member family leave, I understand documentation from the appropriate branch of the Armed Forces is required referencing need for support of the contingency operation.
- I understand that under the provisions of Parental Leave from University policy, I can take up to six months unpaid leave when I become the biological or adoptive parent of a child. I understand that Parental Leave may not begin more than two weeks prior to the expected date of the child's arrival without supervisor and HR approval. **Exception for Faculty covered under FAU's United Faculty of Florida (UFF).**
- Should HR not receive my completed documentation, and I remain absent from employment with FAU, I understand that I may be subject to termination from my position, consistent with FAU's policies and regulations regarding attendance and unexcused absences.

Employee Signature

Date

Please fax completed form to Division Employee Relations and Development, Department of Human Resources at **561. 297. 1256** or email **emprels@fau.edu**.