Family Medical Leave Request Form

Name: _____ SSN: _____

Home Address: _____ Home Phone: _____
(P.O. Box or Street Address)

_____ Work Phone: _____
(City)

_____
(State / Zip)

Department: _____ Supervisor's Name: _____

Date of Employment: _____ Your Position: _____

Request is for: ☐ birth, adoption, or foster placement
(check one) ☐ serious health condition of employee
☐ care for spouse, son, daughter, or parent with a serious health condition

Note: If FMLA is requested for care of your spouse, son, daughter, or parent with a serious health condition, the following information must be provided:

Name of spouse, son, daughter, or parent and explanation of relationship: _____
_____
_____

Briefly explain reason for leave request: _____
_____

Date FMLA leave is to begin: _____ Date expected to return to work: _____

I certify that I understand, agree to, and meet the requirements and conditions set forth in the Family and Medical Leave Act policy as outlined in the *Personnel and Policy Manual* of Sandhills Community College. I authorize Sandhills Community College to obtain any necessary information regarding my request for Family and Medical Leave.

_____ _____
(Employee's Signature) (Date)

_____ _____
(Supervisor's Signature) (Date)

Employer Response to Employee Request for Family and Medical Leave

Leave approved: ☐ Yes Date approved leave begins: _____
(check one) ☐ No Date approved leave ends: _____

Number of workweeks used for FMLA: ____ Leave used: _____hours sick leave
If denied, reason for denial: _____ _____hours vacation
_____leave without pay

HR Director's Signature: _____ Date: _____

Vice President's Signature: _____ Date: _____

10/10/02