



Human Resources

Clear form

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.

- 1. Yes/No Counting any periods of time you worked for the University System of Georgia...
2. Yes/No During the past 12 months, have you worked at least 1,250 hours...
3. Yes/No Have you previously received medical or family leave?

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

Details for question 5

- 6. Yes/No Is your spouse employed by the University System of Georgia, University System Office? 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 _____

TO BE COMPLETED BY SUPERVISOR OR DEPARTMENT HEAD

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

Employee 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 Section and will be maintained in the HR Benefits Section.

Prior leave requests confirmed: _____

Leave is Approved

Denied for the following reason(s)

Request approved /denied by: _____ Date: _____

- Complete the FMLA Departmental Response to Employee form
- Provide a copy of this form and the Approval/Denial form to the employee