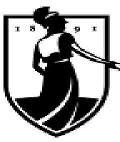

UNCG
Human Resources

HUMAN RESOURCES RECEIVED

Date: ________________

Family & Medical Leave Request Form

I. EMPLOYEE DATA

Employee Name:		**Employee ID:**	
Phone:		**Department:**	
Email Address:		**Date of Hire:**	
Appointment Information:	☐ Full Time:		
	☐ Part-Time- Hrs./Wk:		
Supervisor:		**Supervisor Email:**	

II. LEAVE REQUEST

Reason for leave:

☐ For incapacity due to pregnancy, prenatal medical care or childbirth (Birth parent only)
☐ To care for your child after birth or placement of a child with you for adoption, foster care or other legal placement
☐ Your own serious health condition
☐ To care for a family member due to their serious health condition
☐ Because of a qualifying exigency arising out of the fact that your family member is on covered active duty or call to covered active duty status with the Armed Forces
☐ Because you are the family member or next of kin of a covered service member with a serious injury or illness

Requested FMLA Leave Start Date: ____________________ **Requested FMLA End Start Date:** ____________________

Type of Leave Requested (please check one): ☐ Continuous / Block Leave ☐ Intermittent Leave ☐ Reduced Schedule

If you are requesting intermittent leave or reduced work schedule, please describe your schedule below:

III. REQUIRED DOCUMENTATION (Due within 15 days of completing this form)

Placement of a child with you for adoption, foster care or other legal placement	Adoption Order, Foster Care Placement Agreement, Custody Order, or Letter of Placement
Your own serious health condition, including incapacity due to pregnancy, prenatal medical care or childbirth	Family Member Medical Certification (FMLA)
Family Member's Serious Health Condition	Family Member Medical Certification (FMLA)
Military Caregiver Leave	Certification for Serious Injury U.S. Department of Labor or Illness of a Veteran for Wage and Hour Division Military Caregiver Leave (Form WH-385-V)
Qualifying Exigency	Certification of Qualifying Exigency U.S. Department of Labor For Military Family Leave

IV. EMPLOYEE CERTIFIACTION AND SIGNATURE

I certify that the information I have provided on this form is accurate and complete. I have read and understand the Family & Medical Leave (FMLA) information available to me on the hrs.uncg.edu website. I understand that FMLA leave runs concurrently with paid or unpaid leave. Any falsification of information may lead to appropriate administrative action, up to and including dismissal from UNCG.

Employee's Signature:		**Date:**	

V. SUPERVISOR ACKNOWLEDGEMENT

I understand that this employee has requested FMLA leave and that reasons for FML requests are confidential.

Supervisor's Signature:		**Date:**	

VI. ROUTING OF DOCUMENTATION

This form is part of UNCG's Leave Administration program. Email this form and the required FMLA documentation to UNCG Benefits at benefits@uncg.edu. For questions, please contact UNCG Benefits at 336-334-5009 or fax 336-334-5585.