

Family & Medical Leave Request Form

I. EMPLOYEE DATA			
Employee Name:		Employee ID:	
Phone:		Department:	
Email Address:		Date of Hire:	
Appointment Information:	<input type="checkbox"/> Full Time:		
	<input type="checkbox"/> Part-Time- Hrs./Wk:		
Supervisor:		Supervisor Email:	
II. LEAVE REQUEST			
Reason for leave: <p> <input type="checkbox"/> For incapacity due to pregnancy, prenatal medical care or childbirth (Birth parent only) <input type="checkbox"/> To care for your child after birth or placement of a child with you for adoption, foster care or other legal placement <input type="checkbox"/> Your own serious health condition <input type="checkbox"/> To care for a family member due to their serious health condition <input type="checkbox"/> 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 <input type="checkbox"/> Because you are the family member or next of kin of a covered service member with a serious injury or illness </p>			
Requested FMLA Leave Start Date: _____		Requested FMLA Leave End Date: _____	
Type of Leave Requested (please check one): <input type="checkbox"/> Continuous / Block Leave <input type="checkbox"/> Intermittent Leave <input type="checkbox"/> 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	Employee Medical Certification		
Family Member's Serious Health Condition	Family Member Medical Certification		
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 CERTIFICATION 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.			