UNIVERSITY OF SOUTHERN INDIANA
REQUEST FOR LEAVE OF ABSENCE
FAMILY AND MEDICAL LEAVE ACT OF 1993 AS AMENDED

Name:_____ Employee ID #: _____

Supervisor's Name(s)_____

I hereby request a leave of absence under the Family and Medical Leave Act (FMLA) for the following reason:

☐ Family leave
1) Birth of a child
2) Placement of a child for adoption
3) Placement of a child for foster care

☐ To care for my spouse, child, or parent who suffers from a serious health condition. Please specify the following:

Name:_____ Relationship:_____

☐ My own "serious health condition"

☐ Qualifying exigency leave for an eligible employee whose spouse, child, or parent in the National Guard or military reserves has been called to active duty

☐ To care for an ill or injured servicemember

The timeframe for this leave is expected to be:

☐ Consecutive leave (up to 12 weeks for any leave except caring for a Servicemember)
Beginning date:_____ Ending date:_____

☐ Intermittent leave
Expected frequency of intermittent flare-ups:_____
Beginning_____ Ending date: _____

☐ Reduced schedule leave
Specify change in schedule requested:_____
Beginning_____ Ending date: _____

If this FMLA leave is due to my own serious health condition, I understand that any sick leave accrued must be used. For a family member's serious health condition, I understand that I must use my sick leave accruals to limits established by policy and contracts. In addition, I understand that I must utilize my currently available compensatory time and accrued vacation time only. Any hours accrued during my leave cannot be used until after I return from my current absence.

I understand the total paid and unpaid time for FMLA leave will not exceed 450 hours (prorated for less than 100% employment) in a 12-month period.

I understand that my insurance benefits will be continued under the same conditions as prior to taking FMLA leave and that I am responsible for any share of the premiums which have been paid by me prior to taking the FMLA leave. If premiums are raised or lowered, I will be required to pay the new premium rates the same as any employee not on a leave of absence. If I fail to return from FMLA leave for at least 30 days, I may be required to reimburse the University for the cost of my insurance benefits that were paid during my leave.

I understand that the University may request initial medical certification, recertification during my FMLA leave, and a medical fitness for duty form before I return to work pursuant to FMLA guidelines. Failure to provide appropriate medical certification may result in denial/delay of FMLA leave.

Employee Signature:_____Date:_____

Employee Printed Name:_____

Human Resources Representative:_____Date:_____