COLUMBUS STATE
HUMAN RESOURCES DEPARTMENT

EMPLOYEE REQUEST FOR FAMILY AND MEDICAL LEAVE

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FML entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient.

DATE: ______________________ DEPARTMENT: ______________________

NAME: ______________________ COUGAR ID: ______________________

EMPLOYEE TELEPHONE NUMBER: ______________________ EMPLOYEE EMAIL: ______________________

How would you like to be contacted regarding your FML status? ______________________

I believe I meet the eligibility requirements[1] of the FMLA and am therefore requesting leave for the following qualifying reasons:

All employees will have a beginning balance (480 hrs. equivalent to 12 weeks) of FML, unless leave has been used within the previous 12 months[2].

Basic Leave Entitlement

☐ The birth of my child and/or to bond with the newborn child within one year of birth

☐ The placement of a child with me for adoption or foster care and/or to bond with the newly placed child within one year of placement

☐ My own serious health condition*

☐ To care for my ☐ spouse ☐ other immediate family member who has a serious health condition (age 18 or under, or a child over age 18 with a disability where the child is unable to perform the activities of daily living without assistance; see definition of immediate family in Columbus State's FML Procedure 3-36 (D)).

☐ A Qualifying Exigency arising out of the fact that my ☐ spouse, ☐ other immediate family member is a covered military member on covered active duty.

Military Family Leave Entitlement

☐ To care for a covered servicemember with a serious injury or illness. I am the servicemember's ☐ spouse, ☐ child ☐ parent, ☐ next of kin

You may be required to furnish certification in accordance with College FML procedures by the Leave Coordinator.

I am requesting leave beginning on: ______________________ and anticipated end date: ______________________

(Insert specific date) (MM/DD/YY) ***(Insert specific date)*** (MM/DD/YY)

I am requesting my leave as ☐ continuous ☐ intermittent ☐ reduced work schedule.

If you have indicated it will be necessary for your leave to be on an intermittent or reduced work schedule basis above, please list the proposed schedule of leave dates and durations below. If leave is not scheduled, describe your anticipated need for leave (estimate the probable number of and interval between treatments or periods of incapacity).

[1] At least 12 months cumulative service and worked at least 1,250 hours during the 12 month period preceding the date the proposed FML is to begin.
[2] The employee must have a remaining balance of FML satisfactory to cover the leave dates in the request.
* A serious health condition as an illness, injury, impairment or physical or mental condition that involves inpatient care or continuing treatment by a health care provider (Policy 3-36 (D)).