



Employee Request for Leave

This form must be completed and returned to the office responsible for Research Foundation personnel before any request for leave will be approved. Questions about leave or this form should be directed to the office responsible for Research Foundation personnel.

Part I: Leave Request Data

Employee's Name: _____ Employee Number: _____
(please print or type)

Reason for Request: Check one

- Birth of Child Placement for Adoption/Foster Care
- Serious Health Condition of Employee *(requires form DB-450)*
- Care for Seriously Ill Family Member *(requires Certification of Physician or Practitioner form WH- 380-F)*

If checked, provide name of seriously ill family member and relationship to employee

Name: _____ Relationship _____

- Because of a qualifying exigency arising out of the fact that your spouse, son/daughter, or parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves. *(requires Certification Form WH- 384)*
- Because you are the spouse, son/daughter, parent or next of kin of a covered service member with a serious injury or illness *(requires Certification Form WH- 385)*

If checked, provide name of seriously ill family member and relationship to employee

Name: _____ Relationship _____

- Other Leave. If checked, specify: _____

Date the request leave is to begin _____ Date you expect to return to work _____

Are you requesting intermittent leave? No ___ Yes ___ If YES, explain intermittent periods.

Are you requesting a reduced work schedule for FMLA leave? No ___ Yes ___ If YES, explain schedule requested.

Have you previously been approved for leave? No ___ Yes ___ If YES, give the dates of the leave period.

Part II: Employee Entitlement and Certification

I understand that:

- To be eligible for FMLA leave, I must have completed one year of service and have worked a minimum of 1250 hours during the 12 month period prior to my leave

- During my period of leave, my group medical, dental and vision coverage will continue at the same level and under the same provisions that are in effect at the time leave begins and that I am fully responsible for my portion of the premium(s) one month in advance. If I fail to remit my premium within the required period, my coverage will cease as of the first of the month for which payment is past due
- I am responsible for notifying the Research Foundation immediately of any change(s) in the leave period
- Upon return from FMLA leave, I am entitled to be restored to my former position or an equivalent one, with equivalent pay, benefits and terms of employment, provided I am not a key employee under FMLA definition whose restoration would cause the Research Foundation to suffer substantial and grievous economic injury

Employee's Signature: _____ Date: _____