WRIGHT STATE UNIVERSITY

Human Resources
3640 Colonel Glenn Hwy
Dayton, OH 45435
Fax: (937) 775-3040
Email: HR-Leave@wright.edu

Family and Medical Leave Request Form

Employee Information

Name: _____ UID / Date of Hire: _____

Address: _____ City: _____ St: _____ Zip: _____

Email Address: _____ Home Phone: _____

Department: _____ Work Phone: _____

Supervisor's Name: _____ Business Manager's Name: _____

Select the leave type(s) that apply: ☐ FMLA ☐ Parental ☐ Military ☐ Disability ☐ Workers Comp

Reason for FMLA Leave (check one for each section)	**Payment During Leave (check all that apply)**
☐ Maternity, Paternity, Placement for Adoption, or Foster Care. The expected date of birth, placement for adoption or foster care _____ ☐ My own serious health condition that makes me unable to perform my job. ☐ Care of my family member who has a serious health condition. Family member's name _____ Relationship of the person to the employee _____ ☐ Qualifying Exigency Leave **Family members include parent, son, daughter, or spouse of the employee, see family member definition under FMLA Definitions for more information.*	☐ **<u>If eligible</u>**, I elect military leave (up to 31 days per year, part time employees are adjusted to an equivalent of this) ☐ **<u>If eligible</u>**, I elect parental leave (up to 3 weeks for father, up to 6 weeks for mother). ☐ **I have <u>no paid leave</u> available**, this leave will be unpaid. *If you wish to maintain benefits, please review the process for benefit premiums during paid leave or contact <u>hr-leave@wright.edu</u>.* **All paid leave **<u>must be exhausted</u>** prior to an unpaid leave status.* **All paid leave **<u>must be exhausted</u>** in order to receive Unum approved disability payments.*
This requested leave will be: ☐ Intermittent ☐ Continuous ☐ Reduced Work Schedule	Begin Date of Leave: _____ End Date of Leave: _____

Employee Certification

I understand that:

- The maximum FMLA leave allowed is 12 weeks in any 12-month period, if FMLA exhausts, the employee will need to contact the Office of Equity and Inclusion to apply for a reasonable accommodation for the leave related to their medical condition.
- This leave will run concurrently with all other applicable leave types (e.g. sick leave, worker's comp, parental leave, disability leave).
- I am eligible to continue my benefits and that, if my leave is unpaid, I will be responsible for remitting the premiums to the Department of Human Resources.
- I have the right, upon return from leave to be returned to my original position or an equivalent position (with equivalent pay, benefits and other terms of employment).
- If I am requesting intermittent leave or a reduced work schedule, and my absences are foreseeable in their nature, I must provide a listing of the schedule being requested.
- I must give notice 30 days in advance for a leave that is foreseeable (e.g., surgery, pregnancy/delivery) and I must give notice within 2 days of the need for leave (or as soon as practicable) when the need for leave is not foreseeable (e.g. an emergency).
- I understand that I must follow established departmental call-in procedures and inform my supervisor or his/her designated representative that I am claiming FMLA when calling in.

_____ _____

Signature of Employee **Date**

Supervisor/Department Acknowledgement

My signature confirms my knowledge of the employee's request for leave, but does not approve the employee's request for leave.

_____ _____

Supervisor's or Department Representative's acknowledgement (Print/Sign) Date