DIXIE STATE COLLEGE
APPLICATION FOR FAMILY MEDICAL LEAVE

Employee Name: _____ Date: _____

Social Security Number: _____ Home Telephone No.: _____

Home Address: _____

Department: _____ Date of Hire: _____

Start Date of Leave: _____ Expected Date of Return: _____

Reason for Leave (explain): _____

_____

NOTE: A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child, or parent must be accompanied by a verifying medical certification from a physician.

Physician's Name: _____ Telephone: _____

Leave Work Area (To be completed by Human Resources Office)

Employee meets eligibility requirements
of a minimum of one year of service and
at least 1,250 hours within the past 12 months.

Yes ( ) No ( )

Comments:

_____
_____
_____
_____

Completed by: _____

Paid Leave Available:

Vacation Leave: _____

Sick Leave: _____

Personal Pref. _____

Total Hours Paid Leave Available: _____

Total Hours Unpaid Leave Available: _____
(FMLA hours allowed - 480 (12 weeks), minus total hours paid leave)

I certify that all of the above information is correct. I assume all liability for any false statements. I hereby authorize my employer to contact my physician to verify the reason for my requested leave. I understand that failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved. If I am able but do not return to work, I will be required to reimburse health plan payments made during the absence.

Employee's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Human Resources Director: _____ Date: _____