



Office of Human Resources
Family and Medical Leave Request Form

(Please return the completed form to the Office of Human Resources, Shineman Chapel)

Employee Name: _____ Requested Date: _____

Department: _____ Title: _____

Start Date of Anticipated Leave: _____ Expected Date of Return to Work: _____

Reason for Leave: _____ birth of child, or placement of a child with you for adoption or foster care

_____ Your own serious health condition _____ Serious health condition of a spouse

_____ Serious health condition of a son or daughter _____ Serious health condition of a parent

_____ Service Member (_____ spouse; _____ son or daughter; _____ parent)

Intermittent or Reduced Leave is Required: _____ Yes _____ No _____ Unsure

If yes, please explain:

Proposed Intermittent Schedule (if known):

Days _____ Time _____

Days _____ Time _____

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information on an individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Employee's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Human Resources Office Information

Notes: _____

Date Received: _____ Doctor's Note Received: _____

Approved: _____ Yes _____ No Notification sent on _____

Leave Plan Balances: Sick: _____ Vacation: _____ Personal: _____