University of Oklahoma- Employee Request for Medical Leave and FMLA

NOTE: Please forward original to your immediate supervisor for authorization. Dean or Director signature is also required. Retain a copy for departmental records and give one copy to the employee requesting leave. Send the *approved original* to Department of Human Resources/ Payroll and Employee Services, 905 Asp Ave., NEL . Questions about this form or about the Family & Medical Leave Act (FMLA) should be directed to Payroll and Employee Services at 325-2961. Additional information and forms are located on the Office of Human Resources' Website (www.hr.ou.edu).

1. To be completed by the person requesting the leave. (Please Print Legibly or Type)	
Name:	EMPLID:
Department:	Department Phone Number:
Home Address:	Campus Address:

2. Dates and amount of leave time requested			
Date leave for medical/FMLA begins. **Enter start date here:**			
Anticipated date medical/FMLA ends. **Enter end date here:**			
Number and type of total anticipated hours requested	Paid Leave	Extended Sick Leave:	Leave Without Pay:

3. Leave requested for the following purpose ☑ **(**check one):	
☐	Paid leave, medical, not FMLA. Note from the Health Care Provider may be required.
☐	The birth of my child or the placement of a child with me for adoption or foster care. Submit the Health Care Provider form located on the OHR website.
☐	Serious health condition. Submit the Health Care Provider form located on the OHR website.
☐	Serious health condition affecting my spouse, child, or parent for which I am needed to provide care. Submit the Health Care Provider form located on the OHR website.

Please Note:
Leave of three (3) consecutive days or more taken for any of the above reasons applies toward the twelve weeks of eligibility for leave provided in the Family & Medical Leave Act (FMLA). FMLA runs concurrently with other types of qualifying leave. FMLA protects employee benefits and job for a minimum of 12 weeks even during leaves without pay.

I understand that I may: 1) Be requested to provide regular medical documentation of my illness or the illness of my immediate family member; 2) Need to provide my department with as much notice as possible for FMLA absences especially in those instances of intermittent leave. 3) Be requested to provide a medical release upon my return to work; 4) Be required to take a fitness for duty physical. Under FMLA I understand that employer contributions for my benefits continue for a minimum of 12 weeks even if leave without pay results.

➡

Employee's Signature / Date

Print Supervisor's Name:	Phone:
Immediate Supervisor's Signature:	Date:
Print Dean / Director's Name:	Phone:
Dean or Director's Signature:	Date: