Family & Medical Leave Request Form

FREDONIA
STATE UNIVERSITY OF NEW YORK

Instructions:

1. **Employee:** Complete Part 1 and forward to immediate Supervisor a minimum of 30 calendar days prior to leave begin date (or as soon as practicable for unforeseeable leave); obtain required Family Medical Leave Act (FMLA) Certification from Human Resources.
2. **Supervisor**: Review request, sign Part 2, and forward to Human Resources for review and processing.
3. **Human Resources:** employee and supervisor will be notified of leave approval status after review of request and receipt of Medical Certification. Contact Shannon Fisher, Employee Benefits Coordinator at 673-3434 with any questions pertaining to family or medical leave, FMLA or this form.

Part 1: EMPLOYEE

Last Name	**First Name**	**Telephone Number**

Mailing Address	**City & State**	**Zip Code**

Department

Unit: ❑ CSEA ❑ UUP ❑ MC ❑ PEF ❑ PBANYS

Shift: ❑ 1st ❑ 2nd ❑ 3rd

LEAVE DETAILS: *Complete the following sections, using COMMENTS box as indicated. Sign and date before giving to immediate supervisor.*

Leave **BEGIN** Date:

Expected **RETURN** to Work Date:

Accruals you will charge during leave:

❑ Sick ❑ Vacation ❑ Holiday Comp
❑ Personal (CSEA only) ❑ Other - *explain in COMMENTS*
❑ None/UNPAID leave - *explain in COMMENTS*

REASON for LEAVE *(Required Certification Forms will be sent by HR):*

- ❑ **Employee's Personal Illness/Serious Health Condition**
- ❑ **Care for a Family Member (Spouse, Child, Parent) with a Serious Health Condition**
- ❑ **Birth of Child**
- ❑ **Adoption/Foster Care Placement of Child**
- ❑ **Military Family Exigency**
- ❑ **Military Family Caregiver Leave**

If you answer YES to any of the following, explain in COMMENTS:

a) Are you requesting intermittent leave (absence taken in separate blocks of time due to a single illness or injury)**?** ❑ YES ❑ NO

b) Are you requesting a reduced or alternate work schedule (based on medical need)? ❑ YES ❑ NO

c) Do you anticipate exhausting paid accruals during your leave? ❑ YES ❑ NO

COMMENTS:

I understand:

- This form does not substitute for department-level time off request or call-in procedures, which must continue to be followed;
- All required Certification forms must be returned to HR within 15 days of receipt;
- During **paid** leave, benefit premiums will continue to be deducted from my paycheck; for **unpaid** leave, information on continuing benefit premium payments will be mailed to me by NYS Department of Civil Service after the Benefits Division is notified of my leave without pay status;
- For leave due to my own serious health condition, medical documentation clearing me to work must be submitted to Human Resources PRIOR to my Return to Work Date; and
- I am responsible for notifying Human Resources and my Supervisor of any changes to information on this form or the status of my leave.

Employee Signature: **Date**:

Part 2: SUPERVISOR

I understand:

- Signing below acknowledges receipt and review of this leave request; and
- This form does not constitute approval of leave or FMLA and does not substitute for Department-level time off request or call-in procedures.

Supervisor Name: **Signature:** **Date**:

Part 3: HUMAN RESOURCES

FMLA? ❑ YES ❑ NO LETTER SENT: _____ FOLLOW UP DATE: _____ COS: _____ SUNY HR : _____ NYBEAS: _____

MEDICAL RECV'D: _____ DATES PER MEDICAL: _____ TO _____ RTW: _____