NC STATE UNIVERSITY
DIVISION OF HUMAN RESOURCES

Family and Medical Leave Request Form

SECTION A: EMPLOYEE INFORMATION

(To be completed by employee and returned to supervisor)

First Name _____ Middle _____ Last Name _____ Employee ID _____

Employee Title _____ Department _____

Home Mailing Address _____

City _____ State _____ Zip Code _____

Work Phone Number _____ Home/Cell Phone Number _____

Classification : ☐ EPA ☐ SPA ☐ Temp ☐ Postdoc Contract Length: ☐ 12 month ☐ 9 month

Employment Status: ☐ Full-time ☐ Part-time Regular Work Schedule : _____

Faculty Only: ☐ Tenured ☐ Non-Tenure, Tenure Track ☐ Non-Tenured, Non-Tenure Track

I am requesting Family and Medical Leave for one of the following reasons:

- ☐ The birth of a child or placement of a child with me for adoption or foster care.
- ☐ My own serious medical condition.
- ☐ I need to care for my spouse, child or parent due to his/her serious health condition.
- ☐ A qualifying exigency due to my spouse, child or parent is on or called to covered active duty in support of a contingency operation in a foreign country, as a member of the regular armed forces.
- ☐ I am the spouse, child, parent, or next of kin of a covered service member with a serious injury or illness.

Use of Leave during FMLA Absence:

Leave to Begin _____ Probable Duration of Leave _____

☐ Continuous ☐ Intermittent ☐ Both Continuous & Intermittent

If you request either Intermittent or Both Continuous and Intermittent Leave, please provide details of your proposed leave schedule.

_____

_____

I plan to:

- ☐ Use all available sick leave , then annual, comp and bonus leave . *
- ☐ Use all available sick leave, then go on leave without pay.
- ☐ Exhaust annual and bonus leave, instead of sick leave, to cover my absence.
- ☐ Exhaust annual and bonus leave, prior to using my sick leave.
- ☐ Go on leave without pay. * *
- ☐ Apply for Voluntary Shared Leave
- ☐ Employee Unavailable to Comment

* If leave is taken for maternity purposes, sick leave can only be used during the period of disability.

* * If the employee is requesting leave for their own serious medical condition they must exhaust all available sick leave prior to taking a leave without pay.

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I am attaching the Healthcare Provider Certificate with this request. ☐ Yes ☐ No

Is this request related to a current workers' compensation claim? ☐ Yes ☐ No

I understand that if I have not included the Healthcare Provider Certification with this request, I will have 15 calendar days to provide a completed Healthcare Provider Certification. I further understand that failure to do so may result in denial of my request.

I understand that the use of annual, sick, bonus, shared leave or leave without pay must be in accordance with current Office of State Personnel and University policies.

Employee Signature _____ Date _____

SECTION B: DEPARTMENTAL ACKNOWLEDGMENT

(To be completed by the Supervisor and forwarded to the Leave Administration Unit.)

Date Request Received _____

Supervisor Name (Printed) _____ Phone Number _____

Signature of Person Completing the Form _____ Date _____

Department Contact _____ Campus Box No. _____

Phone Number _____ Fax Number _____

Employee's Name _____

Total leave balances as of employee's last day worked: **Attach a copy of the employee's monthly breakdown report.**

Annual _____ Sick _____ Bonus _____ Comp _____

Does employee have enough leave to cover his/her absence? ☐ Yes ☐ No

If no, please provide employee with Voluntary Shared Leave Request Form.

If the employee is absent or unavailable to sign, the supervisor should complete both Sections A and B prior to submitting this form to the Leave Administration Unit.

GENETIC INFORMATION NONDISCRIMINATION ACT NOTICE

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the 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 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.

Mailing Address:
Campus Box 7215
Raleigh, NC 27695

Fax Number: (919) 513-2528

Physical Address:
Administrative Services - Bldg II
2711 Sullivan Dr., Suite 200