FAMILY MEDICAL LEAVE PRELIMINARY APPROVAL FORM

NOTICE: The employee shall give 30 day notices to the supervisors of the intention to take leave under the FMLA Policy unless the leave is a medical emergency. In case of emergency, submit form as soon as practical. **Medical Certification must be completed by attending physician and attached with this form.**

BENEFITS PROTECTION: You have a right under the FMLA for up to 12 weeks of paid or unpaid leave in a 12-month period. Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you must be reinstated to the same or equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or (2) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

Employee Information (To Be Completed By Employee)

Name:_____ **Banner Number:** _____

Home Address: _____

Phone Number:_____ **Department:** _____

Supervisor & Title:_____ **Office Phone Number:** _____

Purpose of Leave (Explain):_____

_____

_____

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 am attaching the Healthcare Provider Certification with this request: Yes ☐ No ☐
I am providing the Healthcare Provider Certification to the Leave Office: Yes ☐ No ☐

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 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.

If so, how much time is requested? _____

I,_____, authorize and consent for the appropriate Human Resource representative to contact my health care provider for purposes of clarification and authenticity of my medical certification.

DEPARTMENTAL ACKNOWLEDGEMENT: (TO BE COMPLETED BY SUPERVISOR AND FORWARDED TO THE LEAVE ADMINISTRATION UNIT)

Date Request Received: _____

Supervisor Name: _____ Phone Number: _____

Signature of Person Completing the form: _____ Date: _____

FAYETTEVILLE STATE UNIVERSITY

☐ **Approved** ☐ **Disapproved**

HR Official's Signature: **Date:**_____

Leave Balance

Bonus:_____ **Comp:**_____ **Sick:**_____ **Vacation:** _____

Hours Worked in Previous 12 Months

Month	Year	Hours	Month	Year	Hours	Month	Year	Hours	Total Hours:
January			May			September			
February			June			October			
March			July			November			_____
April			August			December			