



Family & Medical Leave Request Form

Date Received:

Initials:

I. EMPLOYEE DATA

Employee Name:				Banner ID:	
Dept. Name:				Phone:	
Email Address:				Date of Hire:	
Appointment Information:	Date of Hire:	<input type="checkbox"/> Permanent	<input type="checkbox"/> SHRA	<input type="checkbox"/> Full-Time	
		<input type="checkbox"/> Temporary	<input type="checkbox"/> EHRA Non-Faculty	<input type="checkbox"/> Part-Time – Hrs./Wk.:	
EHRA Faculty:	<input type="checkbox"/> 12-Month Appointment <input type="checkbox"/> 9-Month Appointment			Teaching Responsibilities:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Supervisor:				Supervisor Email:	
HR Rep/Officer:				HR Rep/Officer Email:	

II. LEAVE REQUEST

Reason for leave:

For incapacity due to pregnancy, prenatal medical care or childbirth (Birth parent only)

To care for your child after birth or placement of a child with you for adoption, foster care or other legal placement

Your own serious health condition

To care for a family member due to their serious health condition

Because of a qualifying exigency arising due your family member is on covered active duty or call to covered active duty status with the Armed Forces.

Requested FMLA Leave Start Date: _____ Requested FMLA End Start Date: _____

Type of Leave Requested (please check one): Continuous / Block Leave Intermittent Leave Reduced Schedule

If you are requesting intermittent leave or reduced work schedule, please describe your schedule below:

III. REQUIRED DOCUMENTATION (Due within 15 days of completing this form)

Birth or placement of a child with you for adoption, foster care or other legal placement	Birth Certificate, Adoption Order, Foster Care Placement Agreement, Custody Order, or Letter of Placement
Your own serious health condition, including incapacity due to pregnancy, prenatal medical care or childbirth	Medical Certification (Form WH-380-E for employee)
Family Member's Serious Health Condition	Family Member Medical Certification (Form WH-380-F)
Military Caregiver Leave	Certification for Serious Injury U.S. Department of Labor or Illness of a Veteran for Wage and Hour Division Military Caregiver Leave (Form WH-385-V)
Qualifying Exigency	Certification of Qualifying Exigency U.S. Department of Labor For Military Family Leave (Form WH-384)

IV. EMPLOYEE CERTIFICATION AND SIGNATURE

I certify that the information I have provided on this form is accurate and complete. I have read and understand the Family & Medical Leave Act (FMLA). I understand that FMLA leave runs concurrently with paid or unpaid leave. Any falsification of information may lead to appropriate administrative action, up to and including dismissal from Winston Salem State University.

Employee's Signature:		Date:	
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V. SUPERVISOR ACKNOWLEDGEMENT

I understand that this employee has requested FMLA leave and that FMLA leave is confidential.

Supervisor's Signature:		Date:	
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VI. ROUTING OF DOCUMENTATION

Email this form and the required FMLA documentation completed and signed to hrcbenefits@wssu.edu. If you have questions please call Lauretta Baldwin in The Dept. of Human Resources/Benefits at 336-750-8727 or 2830.