

FLORIDA STATE COLLEGE AT JACKSONVILLE

Family and Medical Leave Act (FMLA) Request

Date: _____

Employee Name: _____

Title / Position: _____

Home Address: _____

Home Phone: _____

Department _____

Reports to: _____

Status: Full-Time Part-Time

Hire Date: _____

Length of Service: _____

Have you taken a family or medical leave in the past 12 months? Yes No

If yes, when and how many days? _____

FMLA is unpaid; however, I would like to use my sick and/or annual leave to be compensated while on leave: Yes No

If yes, any special instructions? _____

Family and medical leave is being requested for one or more of the following:

Please Note: Supporting documentation must be provided before approval of all requests.

- For the birth of a child or placement of a child for adoption or foster care.

Expected date of birth or placement: _____ Actual date of birth or placement: _____

Leave to start: _____ Expected return date: _____

- For a serious health condition that makes me unable to perform my job.

Leave to start: _____ Expected return date: _____

- To care for my family member that has a serious health condition. (Check which member below)

Spouse Child Parent

Leave to start: _____ Expected return date: _____

- To care for a covered servicemember that has a serious health condition. (Check your relationship below)

Spouse Child Parent Next of kin

Leave to start: _____ Expected return date: _____

- For a qualifying exigency arising out of the fact that my Spouse; Child; Parent is on active duty or call to active duty status in report of a contingency operation of the National Guard or Reserves.

Leave to start: _____ Expected return date: _____

- For a proposed intermittent or reduced work-day schedule, if applicable. (Subject to supervisor's/employer's approval)

Leave to start: _____ Expected return date: _____

Anticipated work schedule: _____

I understand and agree to the following:

1. I have been employed at Florida State College at Jacksonville for at least 12 months.
2. During the previous 12 months I have worked at least 1,250 hours.
3. A physician's statement or other documentation supporting my leave request must be provided within 15 days.
4. If I fail to return to work after the leave for reasons other than the continuation, recurrence or onset of a serious health condition that would entitle me to Medical Leave or other circumstances beyond my control, I may be financially responsible for the medical insurance premiums that the College paid while I was on leave, depending on College policy.
5. This leave is unpaid unless I am using accrued annual and/or sick leave.
6. Upon expiration of my approved Family and Medical Leave, if I do not return to work or contact my supervisor on or before my expected date of return, the College may assume that I have abandoned my job.
7. I wish to continue, at my expense, my other insurance coverage(s).
8. A leave extension must be approved by my supervisor and the Director of Human Resources prior to the expiration of the leave period.

Employee Signature _____

Date _____

Supervising Administrator Signature _____

Date _____

FMLA2

July 2009

Florida State College at Jacksonville is a member of the Florida State College System. Florida State College at Jacksonville is not affiliated with any other public or private university or College in Florida or elsewhere.

Florida State College at Jacksonville is accredited by the Commission on Colleges of the Southern Association of Colleges and Schools ("SACS") to award the baccalaureate and associate degree. Contact the Commission on Colleges at 1866 Southern Lane, Decatur, Georgia 30033-4097, or call (404) 679-4500 for questions about the accreditation of Florida State College at Jacksonville.