THE UNIVERSITY OF ALABAMA IN HUNTSVILLE
FAMILY AND MEDICAL LEAVE OF ABSENCE FORM

This is notification that your recent request for leave is designated as leave under the Family Medical Leave Act (FMLA). See attached copy of "Your Rights under the Family Medical Leave Act of 1993".

Complete the following sections as applicable. Please Print or Type.

FULL NAME _____ **SOCIAL SECURITY #** _____

DEPARTMENT _____ **SUPERVISOR** _____

TYPE LEAVE REQUESTED: ____**Intermittent** ____**Extended**

REQUESTED LEAVE START DATE: _____/_____/_____ **REQUESTED LEAVE END DATE** _____/_____/_____

REASON FOR LEAVE OF ABSENCE:

FAMILY-RELATED REASONS:

- ❑ Birth of child or to care for the baby (Attach copy of the birth certificate or certification from a health-care provider. Employee's entitlement to leave of absence expires twelve months from the child's date of birth.)
- ❑ Adoption of a child by the employee (Attach a copy of the adoption papers. Employee's entitlement to leave of absence expires twelve months from the date of adoption.)
- ❑ Placement of a child with the employee for foster care. (Attach a copy of the foster care placement papers. Employee's entitlement to leave of absence expires twelve months from the date of foster care placement.)
- ❑ Care of a son, daughter, spouse, or parent (but not in-laws) having a serious health condition. (Attach a copy of the completed "Physician's Certification for Leave under the Family Medical Leave Act". Children 18 years or older are not included unless they are incapable of self care due to mental or physical disabilities.)

EMPLOYEE MEDICAL CONDITION:

- ❑ Medical leave of absence for a serious health condition that makes me unable to work. (You may be required to attach a copy of the completed "Physician's Certification for Leave under the Family Medical Leave Act".)

I understand that if I do not return to work after the leave, UAH may recover payments for health insurance made by the University during any unpaid leave of absence. I understand that failure to return to work on the date stated above as the leave end date or that misrepresentation of facts on this form will jeopardize my reinstatement at the University.

Employee Signature: _____ **Date:** _____/_____/_____

SUPERVISORY APPROVAL:

Supervisor and/or Department Head: _____ **Date:** _____/_____/_____