The University Of Alabama In Huntsville

FAMILY AND MEDICAL LEAVE ACT LEAVE REQUEST FORM

☐ New Request ☐ Leave Extension

Section 1: Employee Information			
Employee Name		**Banner ID**	
Position Title		**Supervisor**	
Mailing Address			
Home Phone		**Campus Phone**	
Department		**Campus Location**	

Section 2: Type of Leave Requested				***Section 3: Paid Leave to be Used***	
☐	Intermittent	☐	Extended	☐	Annual Leave
Begin Date				☐	Sick Leave
End Date				☐	Personal Leave
Anticipated Return to work date				☐	I elect not to use accrued leave

Section 4: Reason for Leave

☐ For incapacity due to pregnancy, prenatal medical care or child birth

☐ To care for the employee's child after birth, or placement for adoption or foster care

☐ Employee's own serious health condition

☐ To care for the employee's family member (spouse, son or daughter, or parent) who has a serious health condition

☐ To care for the employee's family member as a Military Caregiver

☐ For a Military Qualifying Exigency

Employer Designation of Leave as FML Leave:

☐ The employee indicated above has not specifically requested a family and medical leave of absence, but I am designating the employee's leave as a leave which qualifies under the Family and Medical Leave Act. I am notifying the employee of my intent by providing him/her a copy of this completed form. Date mailed: _____

Section 5: Certification

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 misrepresentation of facts on this form will jeopardize my reinstatement at the University. Further, I understand that this leave of absence will count toward my 12 weeks of FMLA leave entitlement, if approved.

Employee Signature _____ *Date* _____

Section 6: *Supervisor Signature*_____ *Date* _____

Section 7: Human Resources Use Only

Leave Request

☐ Contingent upon receipt of medical certification

☐ Approved

☐ Disapproved

Reason _____

Medical Certification Received _____ *Leave Entered* _____

_____

Human Resources Representative *Date*

Once processed, a completed copy will be returned to the employee at the mailing address listed above and to the departmental supervisor.

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Employee Acknowledgement

I have read and understand the following:

I am required to furnish medical certification for a serious health condition for myself, family member or a covered servicemember. I must furnish this certificate within 15 calendar days after applying for Family Medical Leave. For my own medical leave, the certification must include a finding that I am or will be unable to perform one or more of the essential functions of my job.

I am required to furnish certification due to a qualifying exigency for a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves. I must furnish this certificate within 15 calendar days after applying for Family Medical Leave.

For continuation of health insurance, I must continue to pay my portion of the premiums. If I am in a paid status during any part of my leave, usual deductions will be made from my paycheck. If I am in an unpaid status, a Benefits Retention form must be completed to allow me to continue benefits during the unpaid portion of the leave.

I am responsible for timely payment of my portion of premiums for health insurance and other benefits I elect to continue during the leave. If the premiums become past due for 30 days or more a 15-day written notice of termination of health insurance will be issued. If payment is not made within the time specified in that notice, health insurance coverage will be canceled and cannot be reinstated until I return to paid status.

If the leave is due to my serious health condition, I will be required to present a fitness for duty certificate from my physician prior to being restored to employment. If such a certificate is not received, my return to work may be delayed until such certificate is provided.

While on leave, I am required to furnish my supervisor with periodic reports of my status and intent to return to work. The supervisor will determine the interval of such status reports (weekly, monthly etc.) If the circumstances of my leave change and I am able to return to work earlier than the date indicated on the designation form approving the leave I should, where practical, provide up to three days advance notice to my supervisor.

My signature below authorizes the release of my medical information to UAH and release of my Physicians Certification for FMLA Leave form relative to this request. I understand that all medical information is kept confidential.

I may elect to use any accrued sick and/or annual leave time in order to receive pay. FMLA leave runs concurrently with the use of any paid leave. It is my responsibility to continue to submit the Bi-weekly Labor and Leave Reports to the Payroll Office unless I have been placed on "Leave without Pay" status on a PAF (Personnel Action Form).

I understand that if I do not return to work upon the expiration of the requested leave, UAH may recover from me those payments for health insurance made by it during any period of unpaid leave of absence. UAH may recover those payments by taking deductions, to the extent permitted by law, from my unpaid wages, vacation pay, or any pay due me, or by initiating legal action. However, I will not be liable for such payments if the reason I do not return to work is due to: (1) the continuation, recurrence, or onset of a serious health condition affecting me or a family member of mine which would otherwise entitle me to leave under FMLA; or (2) the serious injury to or illness of a covered servicemember; or (3) other circumstances beyond my control.

I understand that if I do not return to work at the expiration of this leave, unless a written extension has been granted in advance, my employment may be terminated.

I understand that misrepresentation of facts, orally or in writing, regarding this requested leave of absence may also result in disciplinary action, including termination of employment.

I have received a copy of the UAH Employee/Family Medical Leave Policy and a copy of My Rights under the Family Medical Leave Act of 1993. These are available on the HR Policy web site regarding FMLA at: www.uah.edu/hr/policies-and-procedures/family-and-medical-leave-act.)

Employee Signature _____ Date _____

Completed forms should be returned to Benefits Office, Human Resources, 102 Shelbie King Hall.
The FMLA Policy and forms can be found on the HR FMLA Policy web site at:
www.uah.edu/hr/policies-and-procedures/family-and-medical-leave-act