FAMILY MEDICAL LEAVE REQUEST FORM

INSTRUCTIONS FOR THE EMPLOYEE:
• Complete the form and submit to Human Resources.

EMPLOYEE INFORMATION

Employee Name	Title	Academy/Department	City

TYPE OF LEAVE

I believe I meet the eligibility requirements of the Family and Medical Leave Act (FMLA) and I am therefore requesting the following type of leave:

☐ Family leave for the:
☐ Birth of my son or daughter OR ☐ Placement of a child with me for ☐ adoption ☐ foster care
Anticipated date of birth or placement:_____

☐ Family leave to care for a spouse, son, daughter, or parent with a serious health condition.
Family member's full name: _____
Relationship to you: ☐ spouse ☐ parent ☐ son or daughter ☐ other (if applicable) _____

☐ Medical leave for my own serious health condition (please review the definition of a serious health condition on page 2 and check the applicable category below):

☐ Hospital care
☐ Pregnancy
☐ Absence Plus Treatment
☐ Permanent/Long-term Conditions Requiring Supervision
☐ Chronic Condition Requirement Treatments
☐ Multiple Treatments (Non-chronic Conditions)

You may be required to furnish medical certification of a serious health condition if requested to do so by the USS Medical Department.

☐ Service Member Care ☐ Exigency Leave

Have you taken FMLA in the past 12 months? ☐ Yes ☐ No

TIME PERIOD

1. I request that the leave be granted for the following time period: Begin date: _____ End date: _____

2. I further request that the leave be granted for the following reduced or intermittent leave schedule:
_____

3. You must take all available PTO while out on leave, but it is your choice to use sick, personal or vacation in whatever order (e.g., you are out for 2 weeks, you may not want to take all the time from vacation and leave your sick time.)
Indicate leave use preference _____

EMPLOYEE CERTIFICATION AND SIGNATURE

I Hereby Certify that the information given above is true and correct to the best of my knowledge. I understand that misrepresentation or omission of the reason for leave or any facts supporting the need for leave will result in denial of the leave and will subject me to discipline up to and including termination.

Signature: _____ Date: _____

HR USE ONLY - MAINTAIN THIS FORM IN A CONFIDENTIAL FMLA FILE

Leave Approved ☐ Yes ☐ No For what period?	Expected Return Date	
The following paid leave will be substituted (check all that apply): ☐ Vacation ☐ Sick ☐ Personal	Insurance Premium to be paid as follows:	
Remarks		
Signature	Title	Date

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"Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (i.e. an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

a. A Period of incapacity of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

1. **Treatment two or more times** by a health-care provider, by a nurse or physician's assistant under the direct supervision of a health-care provider, or by a provider of health-care services (e.g. physical therapist) under orders of, or on referral by, a health-care provider; or
2. **Treatment** by a health-care provider on **at least one occasion** which results in a **regimen of continuing treatment** under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. Chronic Conditions Requiring Treatments

A **chronic condition** which:

1. Requires **periodic visits** for treatment by a health-care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
2. Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and
3. May cause **episodic** rather than a continuing period of incapacity (e.g. asthma, diabetes, epilepsy, etc.)

5. Permanent/Long-term

Conditions Requiring Supervision

A period of **incapacity** which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health-care provider.**

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive **multiple treatments** (including any period of recovery) by a health-care provider or by a provider of health care services under orders of, or on referral by, a health-care provider, either for **restorative surgery** after an accident or other injury, or for a condition that **would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).