



**UTAH STATE UNIVERSITY  
Request for Family and Medical Leave of Absence (FMLA)**

All employees with appointments of 50% time or more in their regular assignments who have worked for a full year and who have worked 1,250 hours or more over the previous 12-month period are eligible. The Office of Human Resources will determine whether or not the employee qualifies for FMLA and will notify the employee of the decision.

<b>Employee Information</b>	
Name: _____ A# _____	
E-mail address: _____ Work Phone: _____ Home Phone: _____	
Supervisor's Name: _____ Supervisor's e-mail address: _____	
Department: _____ Supervisor's Phone Number: _____	
Reason for FMLA Request	Type of FMLA Request
<p><b>Check all that apply:</b></p> <input type="checkbox"/> Maternity, Paternity, Adoption, or Foster Care <input type="checkbox"/> Serious Health Condition – <i>A completed Certification of Health Care Provider is required</i> <input type="checkbox"/> Employee <input type="checkbox"/> Employee's Spouse <input type="checkbox"/> Employee's Parent <input type="checkbox"/> Employee's Child <input type="checkbox"/> Qualifying Exigency ( <i>see USU Policy 359 Military Leave</i> ) <input type="checkbox"/> Military Caregiver ( <i>see USU Policy 359 Military Leave</i> )	<p><b>Check one:</b></p> <input type="checkbox"/> Continuous Leave <input type="checkbox"/> Reduced Work Schedule* <input type="checkbox"/> Intermittent* Current Work Schedule _____ Requested Work Schedule _____ <small>*Available if Health Care Provider Certifies Medical Necessity</small>
<b>Begin Date of Requested Leave:</b> ____/____/____	<b>End Date of Requested Leave, if known</b> ____/____/____
I affirm the above information is true and I have attached appropriate certifications.	
<b>Employee Signature:</b> _____ <b>Date:</b> _____	
<b>Supervisor Acknowledgment</b>	
I acknowledge the above employee's request for Family/Medical Leave. I understand that if this request is approved in accordance with the Family and Medical Leave Act and its amendment(s), the employee will be returned to the same or equivalent position at the end of the leave period.	
<b>Supervisor Signature:</b> _____ <b>Date:</b> _____	
<b>Send completed form to: Office of Human Resources, 8800 Old Main Hill, UMC 8800, or fax to (435) 797-1816.</b>	