

Savannah State University

Family and Medical Leave Request

Date

To be completed by employee:

Employee name _____ Social Security Number _____

Job title _____ Supervisor or Dept. Head _____

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to up to 12 weeks of job-protected leave for certain family and medical reasons. Submit this request form to your supervisor or department head at least 30 days before the leave is to commence, when possible. When submission of the request 30 days in advance is not possible, submit the request as early as is possible. The employer reserves the right to deny or postpone leave for failure to give appropriate notice when such denial/postponement would be permitted under federal or state law.

- Yes No Counting any periods of time you worked for the University System of Georgia (whether they were consecutive or not), have you worked for USG for a total of 12 months or more? (If "yes," continue to question 2. If "no," stop here. Sign and submit this form to your supervisor or department head.)
- Yes No During the past 12 months, have you worked at least 1,250 hours (approximately eight months of 40-hour weeks or one year of 25-hour weeks)? (If "yes," continue to question 3. If "no," stop here. Sign and submit this form to your supervisor or department head.)
- Yes No Have you previously received medical or family leave?
If yes, provide information below:

Dates of leave _____ to _____
Purpose of leave

- Yes No Have you taken any intermittent medical leave?

- Yes No Have you taken time off from scheduled hours?
If "yes," provide details

- Yes No If married, is your spouse employed by the University System of Georgia?
 Yes No If "yes," is your spouse employed at same institution?

Spouse's name

Reasons for requesting leave

Leave must be granted for any of the following reasons:

- For a serious health condition that prevents you from performing the duties of your job;
- To care for your child, spouse, or parent who has a serious health condition; or
- To care for your child after birth, or for placement after adoption or foster care.

I request leave for the following reason:

- Personal serious health condition
- Serious health condition of: spouse child parent
- Birth of a child
- Adoption or placement of a child for foster care

Scheduled date of adoption or placement

Dates of leave requested

I request leave from _____ to _____

The total number of leave hours I request is

I request intermittent leave according to the following schedule:

I request a reduced schedule leave according to the following schedule:

Employee statement

I agree to return to work on _____. If circumstances change such that I will be unable to return to work on that date, I agree to inform my supervisor by submitting written notice. I understand my benefits will continue during my leave and I must arrange to pay my share of applicable premiums.

Signature _____ Date _____

EMPLOYEE: Submit this completed original form to your supervisor. Keep a copy for your records.

- EMPLOYER:**
- Keep this original form in the employee's home departmental files
 - Complete the *FMLA Institutional Response to Employee* form and give a **copy** to the employee