Sandhills Community College

Family Medical Leave Request Form

Name: _____ SSN: _____

Home Address: _____ Home Phone: _____
(P.O. Box or Street Address)

_____ Work Phone: _____
(City)

_____
(State / Zip)

Department: _____ Supervisor's Name: _____

Date of Employment: _____ Position: _____

Request is for: **(check one)**

- ☐ birth, adoption, or foster placement of a child
- ☐ serious health condition of employee
- ☐ care for spouse, son, daughter, or parent with a serious health condition (dependant under age 18; or age 18/older and incapable of self-caredue to a disability)
- ☐ serious health condition that renders employee unable to perform job
- ☐ qualifying exigency due to employee's spouse, son/daughter, or parent who is on active duty or has been notified of an impending call to active duty status in support of a contingency operation as a member of the National Guard or Reserves (or as a retired member of the regular Armed Forces or Reserves). **Please complete FORM WH-384, *"Certification of Qualifying Exigency for Military Family Leave"* (in addition to this form).**
- ☐ servicemember family leave as a spouse, son/daughter, parent, next of kin of a covered servicemember with a serious injury or illness. Please complete **FORM WH-385, *"Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave"* (in addition to this form).**

***Note*:** If FMLA is requested for non-military care of your spouse, son, daughter, or parent with a serious health condition, the following information must be provided:

Name of spouse, son, daughter, or parent and explanation of relationship: _____
_____
_____

Briefly explain reason for leave request: _____
_____
_____

Date FMLA leave is to begin: _____ Date expected to return to work: _____

Once the completed Certification Form has been evaluated, another form will be used to confirm eligibility of leave.

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Please return the requested documents to the Human Resources Department at your earliest convenience or within fifteen (15) days of receipt.

The employee's signature is acknowledgement that he/she have been informed of the allowable time that may be taken away from work under FMLA leave in a 12-month period. The college will measure the 12-month period forward from the date of the employee's first FMLA leave usage. During the time that FMLA leave is taken, employee health coverage will remain in effect under the same terms as when the employee was working. The employee will remain responsible for contribution(s) toward payment(s) of premium(s) that he/she would normally be required to make. It is the responsibility of the employee to contact the Payroll Office to discuss continuation other benefits while on FMLA Leave. The employee is also responsible for informing the Human Resources Department periodically about his/her status and intent to return to work.

Certification:

I certify that I understand, agree to, and meet the requirements and conditions set forth in the Family and Medical Leave Act policy as outlined in the Personnel and Policy Manual of Sandhills Community College. I authorize Sandhills Community College to obtain any necessary information regarding my request for Family and Medical Leave.

(Employee's Signature)	(Date)
(Supervisor's Signature)	(Date)