LEAVE OF ABSENCE REQUEST
For Family or Medical Leave

Name	DU ID	Date
Department	Hire Date	Dates Previously employed, if any

To be completed by Employee

I request a leave of absence from _____ to _____ for the purpose of:
(Check one of the reasons below.)

Medical Leave:
□ Employee's serious health condition
□ Pregnancy related disability

Family Leave:
□ Parent's care of child following birth
□ Placement of a child with employee for adoption or foster care
□ Serious health condition of an employee's child under 18 years (or older if child is disabled)
□ Serious health condition of employee's spouse or parent

Is leave request for: □ a single block of time, or □ intermittent/reduced work schedule?
If intermittent/reduced schedule, please explain: _____
_____

I understand certification may be required for leave due to serious health condition or pregnancy-related disability, in order for leave to be granted.

If leave is taken, I can be reached while on leave at:
Telephone: _____
Address: _____
Employee Signature: _____

To be Completed by Employee's Supervisor

Number of months actually worked by employee._____
(12 months of service are required to be eligible for FMLA. The 12 months need not be consecutive.)
Number of hours worked in 12 months prior to start of leave requested._____
(1,250 hours in preceding 12 months are required for eligibility under FMLA.)
Employee is □ eligible □ not eligible for leave under the FMLA.

Management Signature: _____
Management Print Name: _____
Date: _____