Southwestern University

Request for Family or Medical Leave

Request for Family or Medical Leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin.

Name_____ Date_____

Department_____ Title_____

Status: ☐ Full TIme ☐ Part-Time ☐ Temporary

Hire Date____/____/____ Length of Service_____

I request Family or Medical Leave for one or more of the following reasons:

☐ Because of the birth of my child and in order to care for him/her.

Expected date of birth___/___/___ Actual date of birth___/___/___

Leave to start___/___/___ Expected return date___/___/___

☐ Because of the placement of a child with me for adoption or foster care placement.

Leave start___/___/___ Expected return date___/___/___

☐ For a serious health condition that makes me unable to perform my job responsibilities. Please describe:_____

_____

Leave to start___/___/___ Expected return date___/___/___

*A physician's certification may be required for leave due to a serious health condition.

☐ To care for my spouse, child, or parent, who has a serious health condition.

Leave to start___/___/___ Expected return date___/___/___

☐ To care for an active member of the Armed Forces

Leave to start___/___/___ Expected return date___/___/___

☐ Baby Bonding Time - must start and end within a one year period. Not for intermittent use. Still falls under the 12 or 16 week allocation.

Leave to start___/___/___ Expected return date___/___/___

☐ Requested intermittent leave schedule - explain schedule, etc.(if applicable; subject to employer's approval)

_____

_____

_____

Have you taken a family or medical leave in the past 12 months: ☐ yes ☐ no
If yes, how many work days?_____

I understand and agree to the following provisions:

- I have worked for my employer at least one year and at least 1250 hours in the previous 12 months.
- If I fail to return to work after the leave for reasons other than the continuation, recurrence or onset of a serious health condition that would entitle me to Medical Leave or other circumstances beyond my control, and if my employer requires it, I will be financially responsible for the medical and life insurance premiums the University paid while I was on leave.
- This leave will require the use of up to at least 75% of accrued sick leave and vacation leave, balance to be unpaid, or in the case of my own disability, payment may occur under the University's disability insurance plan, if I am so covered.
- I may be required to exhaust my paid sick, personal or vacation leave as part of my 12 or 16 weeks of leave.
- After my 12 or 16 weeks of leave, if I do not return to work or contact my supervisor or manager on the date intended, it will be considered that I abandoned my job.

Employee Signature_____ Date_____/____/_____

LEAVE APPROVAL

For full day leave:

Human Resources Signature_____ Date_____/_____/_____

For intermittent or reduced day leave:

Human Resources Signature_____Date_____/_____/_____

PAYROLL INSTRUCTIONS

☐ With pay from ____/____/____ to ____/____/____

☐ Without pay from ___/____/____ to ____/____/____