

**REQUEST FOR TIME OFF
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)**

From: _____
Employee Name and Department

To: _____
Supervisor or Department Head Name

Employee's Current Address: _____

This serves as notification that I am requesting time off under the Family and Medical Leave Act (FMLA) for the reason(s) checked below:

- | | |
|---|--|
| <input type="checkbox"/> Birth of a child | <input type="checkbox"/> Serious work-related health condition |
| <input type="checkbox"/> Placement of a child for adoption or foster care | <input type="checkbox"/> Serious health condition of spouse, child or parent |
| <input type="checkbox"/> Serious non-work-related health condition | <input type="checkbox"/> Other: _____ |

Additional Information (Optional): _____

Start Date of Anticipated Leave: _____ Expected Date of Return to Work: _____

- I expect to take full time off for the time period indicated above
 I expect to take a reduced schedule or intermittent time off for the time period indicated above. The details of the reduced schedule or intermittent time off are as follows:

A physician's certification: Is enclosed Not enclosed Will be provided

I understand that a fitness for duty certificate from my physician may be required before I return to work. I also understand that my employment with the Health Science Center may be terminated upon my failure to return to work on the expected date of return or upon the expiration of all my FMLA and leave entitlements.

Employee's Signature

Date