# CENTRAL TEXAS COLLEGE
# FAMILY/MEDICAL LEAVE ----- REQUEST FOR LEAVE FORM
**Human Resource Management Policy #390: Family Medical Leave Act of 1993**

**Please Type or Print**

## COMPLETED BY EMPLOYEE -- SIGNATURE REQUIRED

**1. Name of Employee** (Last Name, First Name, MI) _____

**SSN:** _____

**2. Job Title:** _____

**Department:** _____

**3. Reasons for Requested Leave: (See HR Policy #390 for Details)**

a. ☐ Birth of a son or daughter of the employee and in order to care for such son or daughter,

b. ☐ Placement of a child with employee for adoption or foster care,

c. ☐ In order to care for spouse, child or parent ("covered relation") with a serious health condition,

☐ Spouse ☐ Child ☐ Parent (Please provide Name and Address of Relation Below):

_____

d. ☐ Because of my own serious health condition which makes me unable to perform the functions of my position.

e. ☐ Other (Please Explain)

**4. Leave Start Date:** _____

**5. Anticipated Return to Work Date:**
**(If Known)** _____

**6. Are You Requesting Leave on an Intermittent (Periodic) Basis?** ☐ **YES** ☐ **NO**
**If YES, Please provide anticipated schedule, if known.** _____

Employees seeking leave because of reasons above, must complete the approved Medical Certification Form and return it within **15 days of Leave Start Date** , or as soon as practicable. I understand that my leave may be delayed until I provide a completed Medical Certification Form.

Further, I understand and agree that:

a. Prior to resuming the duties of my position because of 3a. or 3d. above, I must provide a completed and unconditional Return to Work Medical Certification Form. If an unconditional release is not possible and an accommodation is possible within my position, I understand that I must arrange such accommodation with my supervisor. If accommodation is not possible due to the nature of the job, I understand that I may not be permitted to return to work until I am fully capable of performing all of my job functions without limitation.

b. If the time allowed for FMLA has expired and I am not capable of fully performing all of my duties, I understand that I may be terminated by Central Texas College without cause.

c. I will lose eligibility for FMLA if my return to work is not as a full-time employee.

d. If the FMLA leave is for condition 3b. above, I will provide official documentation from the appropriate courts within 15 days of the start of the leave, that fully supports the placement of a son or daughter in my care.

e. If the FMLA leave is for 3c. above and I am not fully capable of performing my duties on the expiration date of the leave, that I may be terminated by Central Texas College without cause.

I hereby agree that while I am on leave, I will continue to pay premiums for any optional insurance coverage, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse Central Texas College for the cost of health benefits provided by Central Texas College during my leave.

**Signature of Requestor:** _____ **Date:** _____

**This form may be sent by facsimile to: (254) 526-1170 or mailed/delivered to:**
**Central Texas College, P.O. Box 1800, Killeen, TX 76540-1800 ATTN: Employment Services - FMLA**
**3 Copies Required: Original to Employment Services; Copy 2 to Supervisor; Copy 3 to Employee**

**02/06**