

**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

<b>COMPLETED BY EMPLOYEE -- SIGNATURE REQUIRED</b>	
<b>1. Name of Employee</b> (Last Name, First Name, MI) _____ <b>SSN:</b> _____	<b>2. Job Title:</b> _____  <b>Department:</b> _____
<b>3. Reasons for Requested Leave: (See HR Policy #390 for Details)</b>  a. <input type="checkbox"/> Birth of a son or daughter of the employee and in order to care for such son or daughter, b. <input type="checkbox"/> Placement of a child with employee for adoption or foster care, c. <input type="checkbox"/> In order to care for spouse, child or parent ("covered relation") with a serious health condition, <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent (Please provide Name and Address of Relation Below): _____ d. <input type="checkbox"/> Because of my own serious health condition which makes me unable to perform the functions of my position. e. <input type="checkbox"/> Other (Please Explain)	
<b>4. Leave Start Date:</b> _____	<b>5. Anticipated Return to Work Date:</b> <b>(If Known)</b> _____
<b>6. Are You Requesting Leave on an Intermittent (Periodic) Basis?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>If YES, Please provide anticipated schedule, if known.</b> _____	
<p>Employees seeking leave because of reasons above, must complete the approved Medical Certification Form and return it within <b>15 days of Leave Start Date</b> , or as soon as practicable. I understand that my leave may be delayed until I provide a completed Medical Certification Form.</p> <p>Further, I understand and agree that:</p> <p>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.</p> <p>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.</p> <p>c. I will lose eligibility for FMLA if my return to work is not as a full-time employee.</p> <p>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.</p> <p>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.</p> <p>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.</p>	
<b>Signature of Requestor:</b> _____ <b>Date:</b> _____	

**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**