

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) Jnae R. Doe _____ SSN: <u>111-11-1111</u>	2. Job Title: Coordinator Department: <u>Systems</u>
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. <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 checked="" 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)	
4. Leave Start Date: <u>01/02/06</u>	5. Anticipated Return to Work Date: (If Known) <u>02/28/06</u>
6. Are You Requesting Leave on an Intermittent (Periodic) Basis? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If YES, Please provide anticipated schedule, if known, <u>Every Monday and Wednesday</u>	
<p>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.</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>	
Signature of Requestor: <u>PLEASE SIGN, DATE & RETURN TO EMPLOYMENT SVCS</u> 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