

University of Louisiana at Lafayette
Request for Family and Medical Leave (FMLA)

Date _____

Employee Name: _____ SS No: _____

Department: _____ Job Title: _____

In accordance with the Family and Medical Leave Act of 1993, you have a right under this Act (FMLA) to take a maximum of twelve (12) weeks of leave; or 26 weeks of leave under the National Defense Authorization Act, in a 12-month period for reasons listed below.

Also, your health benefits (if you have them with UL Lafayette) must be maintained during any period of unpaid leave under the same conditions as though you continued your employment; as long as, you pay your share of the premiums. FMLA also provides that you must be reinstated to the same or equivalent job with the same salary, benefits, and terms and conditions of employment upon your return from leave. You may be required to furnish medical certification of a serious health condition.

I am applying for Family/Medical Leave for the following reason:

- A serious health condition for which I need care.
- The birth of a child, or the placement of a child for adoption or foster care.
(If both the father and mother are employed by the University; the total leave to be taken by both parents is limited to twelve (12) weeks)
- A serious health condition affecting my ___ spouse, ___ child, ___ parent, for which I am needed to provide care.
- A covered family member's active duty or call to active duty in the Armed Forces
- To care for a servicemember with a serious injury or illness

This leave is to begin on _____ and return to work on or about _____.

- I request to use my ___ annual, ___ *sick, ___ compensatory leave.
(*Sick leave can only be used for employees' illness or injury only)
- I request to be given ___ leave without pay (lwop) during this period of absence.

Date

Employee Signature

Department Head

Human Resources