REQUEST FOR FAMILY MEDICAL LEAVE (FMLA)

To be considered eligible for FMLA leave, the employee must have been employed by the state for at least 12 months; and have worked at least 1,250 hours during the 12 months prior to the commencement of FMLA leave.
Employees are expected to give as much advance notice as possible when requesting FMLA leave and to make all reasonable efforts to minimize the disruption caused by their absence. **The employee is required to substitute any available accrued paid leave for any part of the applicable leave provided under the Family Medical Leave Act.**

Refer to MSU Family Medical Leave OP 52.77

Employee Name: _____ M# _____

Home Address: _____
(City) (Zip)

Contact Phone#: _____ Department: _____

Leave Request & Duration

☐ **Continuous leave** - leave request during a single block of time (for example, three weeks of leave for surgery and recovery)

☐ **Intermittent leave or reduced work schedule** – (for example, a chronic, severe medical condition requiring recurrent treatment by a licensed practitioner)

You may use up to a total of 12 weeks (or 480 hours) of FMLA during a 12-month period, intermittently or consecutively, excluding weekends. The 12-week period begins on the date that the employee's Family and Medical Leave begins. For Military Caregiver Leave, the maximum award of time is up to 26 weeks within a single 12-month period.

FMLA Begin Date:	**FMLA End Date:**

FMLA Eligibility - Please check one of the categories relating to the employee's medical condition or request:

1. ☐ Childbirth/Adoption/Foster Child
   Expected delivery date: _____ I am requesting to use ☐ 6 weeks ☐ 8 weeks ☐ 12 weeks
2. ☐ Employee's Personal Illness
   Type of Illness _____
3. ☐ Care for a seriously ill immediate family member ☐ Spouse ☐ Child ☐ Parent
   List type of care required: _____
4. ☐ Military Caregiver Leave (care for a covered service member or for qualifying exigency for military family leave)

I certify that the information above is accurate. I understand that I will provide necessary medical certification and documentation in order to be considered for approval. I will need to notify my department and/or Human Resources immediately if any of the information above should change.
**For placement of a child with adoption or foster care: Attach Adoption/Foster Care Placement Certification (page 2 is not required)*
**For Military Leave: Attach supporting documentation for the request*

Employee _____ Date _____

As the supervisor of the employee listed above, I am aware that the employee has applied for Family Medical Leave. I will notify Human Resources immediately if I become aware of any changes to the information above.

Supervisor _____ Date _____

MIDWESTERN STATE UNIVERSITY
REQUEST FOR APPROVAL / FAMILY MEDICAL LEAVE BENEFITS
ATTENDING LICENSED PRACTITIONER'S STATEMENT

The Genetic information Nondiscrimination Act of 2008 (GINA) prohibits employers from requesting or requiring disclosure of genetic information on an individual employee or his/her family member, except as specifically allowed by this law.

To be completed by attending licensed practitioner (See employee's signed release, page one)

1. Which of the categories below best describes the patient's condition?
   An illness, injury, impairment, or physical or mental condition involving the following:

☐ (1) Childbirth	☐ (2) Employee's Personal Illness
☐ (3) Care for a seriously ill immediate family member (choose one) ☐ Spouse ☐ Child ☐ Parent	

2. Explain how the condition of the patient meets the criteria of the categories marked above.

3. Is the patient's condition a severe condition or combination of conditions affecting the mental or physical health that requires the services of a licensed practitioner? ☐ Yes ☐ No

4. Will the patient's condition possibly result in death if not treated promptly or on regularly scheduled intervals? (Chemotherapy treatments, etc.) ☐ Yes ☐ No
   If yes,
Type of treatment: _____
Schedule of treatments: _____

5. The employee must remain off work for (choose one):

   ☐ 2-4 weeks ☐ 6 weeks ☐ 8 weeks ☐ other _____ (if other, include dates employee cannot work)

If the employee has requested intermittent leave, will the employee need to work part-time or on a reduced hour schedule to care for the medical condition or to assist in the medical care of an immediate family member? ☐Yes ☐ No

_____ Hours per day _____ Hours per week from _____(date) through _____(date).

6. If the patient is **NOT** the MSU employee, does the patient require assistance for basic medical or personal care, transportation to medical care, psychological support, or to ensure safety? ☐ Yes ☐No.

   Estimated duration of care: _____ (dates)

7. **Certification of attending Licensed Practitioner**
   I attest the above statements are true and complete to the best of my knowledge.

_____ _____
Signature of Licensed Practitioner **Date**

_____ _____
Printed Name **Phone #**

Return completed forms and/or proper documentation to:
Midwestern State University Human Resources Department
Hardin Administration Bld., Rm 210 / Phone (940)397-4207 / Fax (940)397-4780
Email ivon.mendoza@msutexas.edu