MSU TEXAS
MIDWESTERN STATE UNIVERSITY

HUMAN RESOURCES

REQUEST FOR FAMILY MEDICAL LEAVE (FMLA)

FMLA allows eligible employees to take up to 12 weeks of unpaid leave, or to substitute appropriate paid leave, for an FMLA qualifying event. Job protection and state-paid employee health benefits will be maintained during the approved leave.

Eligibility for family and medical leave is limited to employees who have worked for the State for at least 12 months. The 12 months of employment do not need to be consecutive or continuous. In addition, the employee must have worked a minimum of 1,250 hours during the 12 months immediately preceding the start date of family and medical leave.

Refer to MSU Family Medical Leave Policy # 3.341

Employee Name:	**Today's Date:**	**Hire Date:**

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).

The employee is <u>required</u> to furnish a written statement from the licensed practitioner to substantiate the need for intermittent leave and whether leave will be taken as needed or on a set schedule.

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**
a. expected delivery date: _____ **I am requesting to use** ☐ **6 weeks** ☐ **8 weeks** ☐ **12 weeks**

2. ☐ **Employee's Personal Illness**

a. Type of Illness _____

3. ☐ **Care for a seriously ill immediate family member** ☐ **Spouse** ☐ **Child** ☐ **Parent**

List type of care required: _____

4. ☐ **Military Leave (care for a covered service member or for qualifying exigency for military family leave)**

An employee who has been on FMLA leave for more than three consecutive days due to his or her own serious health condition is required to provide **medical certification** of fitness for duty before returning to work.

I certify that the information above is accurate. I understand that I may have to provide necessary medical documentation for any period of FMLA requested and that I will need to notify my department and/or Human Resources immediately if any of the information above should change.

Employee _____Date _____

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

Supervisor _____ Date _____