

# Family and Medical Leave Act (FMLA) Request Form - Vincennes University

Name: Department: Phone Number:

Job Title: Employee ID: Supervisor:

Reason for Leave Request (choose one):

**Birth of a child**

**Your own serious health condition**

**You are needed to care for your spouse due to his/her serious health condition**

**You are needed to care for your child due to his/her serious health condition**

**You are needed to care for your parent due to his/her serious health condition**

Qualifying exigency arising out of the fact that your spouse is on covered active duty /call to covered active duty status in Armed Forces

Qualifying exigency arising out of the fact that your child is on covered active duty/call to covered active duty status in Armed Forces

Qualifying exigency arising out of the fact that your parent is on covered active duty/call to covered active duty status in Armed Forces

You are the spouse of a covered service member with a serious injury or illness

You are the son/daughter of a covered service member with a serious injury or illness

You are the parent of a covered service member with a serious injury or illness

You are the next of kin of a covered service member with a serious injury or illness

Requested Start Date: Requested End Date:

Requesting intermittent or reduced schedule:

Yes

No

**Employee Signature:**

**Date:**

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## Memorandum of Understanding

I understand that I am required to provide a Certification of Health Care Provider form to Human Resources within 15 days of this request. I understand that a FMLA leave is a leave without pay in accordance with the Family and Medical Leave Act Policy. I understand that if my leave is approved, my time away from work will be charged against the 12 weeks of leave to which I am entitled in a rolling back twelve (12) month period as mandated by the Family and Medical Leave Act. Upon approval of this requested leave, I understand I am required to utilize any accrued, unused sick leave available to me, and accrued vacation if I choose, prior to going into an unpaid leave status. In the event that I go into an unpaid status while on leave, I understand that I must contact Human Resources to make arrangements to pay my portion of my benefit premiums.

**Print Employee Name:**

**Employee Signature:**

**Date:**