WESTERN PIEDMONT COMMUNITY COLLEGE

Family and Medical Leave Act (FMLA) Request Form

To be completed by employee

Employee's Name	Department	Phone Number

Job Title	Employee ID

☐ Initial Application
☐ Renewed Application

Home Phone #:

Reason for Leave of Absence

☐ Own illness (not work related)
☐ Care for ill parent/spouse/child
☐ Other
☐ Pregnancy disability
☐ Care for newborn/adopted Child (Date of Birth/Placement)

Answer all:	Yes	No
Do you have SHP insurance?	☐	☐
Are you currently on another leave?	☐	☐
Have you or will you be filling a Disability insurance Claim?	☐	☐

Requested start date	Anticipated end date	Requested intermittent or reduced work schedule

An FMLA leave of absence is a leave without pay. Paid leave (using accrued sick time or vacation hours) shall be substituted for the unpaid leave in accordance with the Family Medical Leave Act Policy

I understand that I am required to use accrued paid time off until leave concludes or accrued balance is depleted. Below is an estimate of paid time off available in my account. **Hours**		**Date Begins (mm/dd/yy)**	**Date Ends (mm/dd/yy)**
	Accrued sick leave		
	Accrued vacation leave		

Employee's Signature	*Date*

I understand that I am required to complete a FMLA Certification of Health Care Provider form and submit the form to Human Resources before my leave commences. I understand that if my leave is approved, my time away from work will be charged against my 12 week leave maximum under FMLA. Upon approval of this requested leave, I am required to utilize all paid time available to me 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 health insurance premiums.

I understand that a Certification of Health Care Provider form (to be received from Human Resources upon receipt of this request) should be returned to Human Resources within 15 days. If I am not able to return the form within the allowed timeframe, I will contact Human Resources for assistance.

If this information is not received in the required timeframe, my leave will be considered unauthorized.

_____ Print Name

_____ Employee Signature