Human Resources
A6200 UCA, 282 Champions Way
Tallahassee, FL 32306-2410
Phone: 850-644-5051
Fax: 850-645-9512

FMLA/PARENTAL LEAVE REQUEST AND NOTICE FORM

PLEASE FAX TO HUMAN RESOURCES WITHIN 24 HOURS OF THE EMPLOYEE REQUESTING LEAVE OR THE DEPARTMENT INITIATING LEAVE

SECTION ONE – TO BE COMPLETED BY THE EMPLOYEE

(Section one must be completed by the department in the employee's absence)

FAMILY AND MEDICAL LEAVE GUIDELINES

I understand that to be eligible for leave under the Family and Medical Leave Act, I must have been employed with the FSU for a cumulative total of **12 months** AND have physically worked a minimum of **1,250 hours** during the 12 months immediately preceding the beginning of the requested leave. If I do not meet eligibility, I understand that my request under FMLA will be denied. If my request for FMLA leave is approved, I understand that this period of leave will count toward the number of workweeks that I am entitled to under the Act. I understand that the 12 month period is a rolling 12 month period measured backward from the first date I use any FMLA leave. I also understand that under the rolling 12 month period, each time I take FMLA leave, the remaining entitlement is the balance of my unused workweeks. I understand that FMLA requests must be renewed or extended if the request and approved FMLA period has elapsed.

PARENTAL LEAVE GUIDELINES

I understand that under the provisions of Parental Leave from University policy, I can take up to six months unpaid leave when I become the biological or adoptive parent of a child. I understand that Parental Leave may not begin more than two weeks prior to the expected date of the child's arrival without supervisor and HR approval. **I understand that Parental Leave may run concurrent with Family and Medical Leave entitlements**. I understand that while on parental leave, I may request and be placed on annual leave with pay to cover any part of the six months period until all or any part of my earned annual leave has been used. I also understand that by completing the required medical certification, I may be allowed to use earned sick leave while on parental leave.

CERTIFICATION

I understand that the Family and Medical Leave/Parental Leave Health Care Certification or the Injured Service Member Health Care Provider Certification form is required at the time of my request for leave due to the serious health conditions of me or my child, spouse, or parent. In the case of placement of a child through adoption or foster care, I understand that appropriate documentation from the agency or jurisdiction placing the child is required. In order to take service-member family leave, I understand documentation from the appropriate branch of the Armed Forces is required referencing need for support of the contingency operation.

_____	_____
Employee's Name (printed)	Department
_____	_____
Job Title	EMPLOYEE ID #
_____	_____
Employee's Signature	Date

CONTACT INFORMATION

Phone Number: _____

Mailing Address: _____

Email Address: _____

Select your preferred method of contact:

□ Phone □ Mailing Address □ Email

□ **Do not update my contact information in OMNI**

EXPECTED LEAVE DATES

Request is for: *(Check all that apply)*

□ FMLA □ Parental Leave □ Qualifying Exigency □ Injured Service Member Leave

□ Continuous Leave Begin Date_____ End Date _____
□ Intermittent Leave Begin Date_____ End Date _____
□ Reduced Work Schedule Begin Date_____ End Date _____

REASON FOR LEAVE

The requested leave of absence is due to the following FMLA qualifying event:
□ Serious health condition of the employee
□ Birth of a child or to care for a newborn child during the 12 months following birth
□ Adoption or foster care placement of a child
□ The employee will care for a (□ spouse □ parent □ child) who has a serious health condition
□ The employee needs to take leave for a qualifying exigency due to a service-member
(□ spouse □ parent □ child) being called to active duty
□ The employee will care for a (□ spouse □ parent □ child □ next of kin) injured while on active duty:
If next of kin, specify relationship to employee_____

PAY STATUS DURING LEAVE

Eligible employees may elect, or FSU may require, employees to use their earned leave (such as sick and annual leave) during FMLA and Parental Leave as long as the use is consistent with FSU Attendance and Leave policies. Request to use leave as indicated below: *(Check all that apply)*

□ Earned leave (sick and annual leave) □ Leave without pay
□ Leave rate of _____hours each pay period and leave without pay rate of ____hours each pay period
□ Working rate of _____hours each pay period and leave rate of ____hours each pay period

INSURANCE

While on FMLA/Parental Leave, FSU continues to pay the employer portion of health benefits. The employee is responsible for continued payment of the employee portion of the premium. To arrange for payment of insurance premiums, the employee must contact the Benefits Department in Human Resources at 850-644-4015.

FITNESS FOR DUTY STATEMENTS

Employees will be required to present a fitness for duty statement certifying that he or she is able to return to work prior to being restored to employment after returning from continuous FMLA leave exceeding 5 business days for their own serious health condition.

HEALTH CARE PROVIDER FORM

Employee's eligible to take FMLA must return the Health Care Provider Form within 15 calendar days from receipt of the eligibility notice. Please furnish these directly to the **FMLA Administrator, Denice Henderson, in Human Resources at MC: 2410 or fax: 645-9512.**

SECTION TWO – TO BE COMPLETED BY THE DEPARTMENT

FMLA REQUEST/INITIATION Check one:

□ Employee requested leave □ Department initiated leave

PAY STATUS DURING THE LEAVE Check one:

□ Employee requested pay status will be honored

□ Employee will be required to use all earned leave before leave without pay (per FSU policy)

INSURANCE

While on FMLA/Parental Leave, FSU continues to pay the employer portion of health benefits. The employee is responsible for continued payment of the employee portion of the premium. To arrange for payment of insurance premiums, the employee must contact the Benefits Department in Human Resources at 850-644-4015.

PERIODIC COMMUNICATION

The employee will be required to contact their supervisor every _____ day(s) of the status and intent to return to work. **(Employees are required to follow all call in procedures for all absences.)**

FITNESS FOR DUTY STATEMENTS

Employees will be required to present a fitness for duty statement certifying that he or she is able to return to work prior to being restored to employment after returning from continuous FMLA leave exceeding 5 business days for their own serious health condition.

DEPARTMENT CERTIFICATION

I certify that, on _____ (**today's date**), the FMLA/Parental Request/Notice was initiated by the department or the employee.

_____ _____

Supervisor's Name (printed) Mail Code

_____

Supervisor's Signature

INSTRUCTIONS TO SUPERVISOR / DEPARTMENT REPRESENTATIVE:

1. **Fax the completed form to the FMLA Administrator, Denice Henderson, in Human Resources at 850-645-9512. This must be received in Human Resources within 24 hours of completion.**

   *** If the department is initiating the FMLA and the employee is unavailable to sign, please complete both sections and forward to Human Resources.**

2. **Human Resources will furnish you with a Notice of Eligibility and Rights & Responsibilities to give to the employee. Upon receipt, please make sure this is hand delivered or mailed within 24 hours.**