FMLA/NJFLA FAMILY/MEDICAL LEAVE OF ABSENCE REQUEST FORM

Name: _____ Rowan ID: _____ Ext: _____
Last First MI

Date of Hire: _____ Email: _____ Home Phone: _____

Department: _____ Supervisor: _____
Dean: _____

Requested leave period: Leave Begin Date: _____ Leave End Date: _____

Phone number where you can be reached while on leave: _____

Please note that only the following events qualify for Federal (FMLA) or NJ State Law (NJFLA). If the leave request is not for one of these events, it will be handled as sick leave or a personal leave of absence request, as appropriate.

I am requesting a leave of absence for the following reason:

( ) The birth of child, or placement of a child in my home for adoption or childcare (including for school closure/childcare related to COVID-19)

( ) A serious health condition that makes me unable to perform the essential functions of my job

( ) A serious health condition affecting my ( ) spouse, ( ) child, ( ) parent, for which I am needed to provide care. (NJFLA definition of 'family' includes anyone with whom you have a 'family' relationship)
Please provide the name of the family member: _____

Please attach the appropriate documentation (i.e., birth certificate, adoption certificate, foster care court order, letter of school / childcare facility closure due to COIVD-19). For a serious health condition, your health care provider must complete the appropriate Certification of Healthcare Provider Form.

Please indicate how you wish to use time balances (indicate specific amounts on lines provided):

( ) pay using **only earned time:** ____ sick, ____ vacation, ____ AL, ____ comp time

( ) using all earned **and unearned time:** ____ sick, ____ vacation, ____ AL, ____ comp time

( ) do not pay; maintain all time balances

Human Resources, Oak Hall South, 201 Mullica Hill Road, Glassboro, NJ 08028-1702
Phone: (856) 256-4134 · Fax: (856) 256-4714

40 East Laurel Road, UEC Suite 1126, Stratford, NJ 08084
Phone: (866) 566-6159 · Fax: (856) 566-6170

If requesting reduced hours or intermittent leave, please describe:

_____

Has a leave been approved for you within the last 12 or 24 months? ( ) Yes ( ) No

I understand that I am responsible for the cost of health and dental benefits while on a leave without pay, and payment for benefits must be provided for ongoing coverage.

I further understand that any false information given to support this request for leave may result in disciplinary action up to and including termination of employment. I also understand that if my request for leave is denied by the University, I may resubmit my request at any time.

Print Employee Name: _____

Employee Signature: _____ Date: _____

HR Use Only: This request for leave has been fully reviewed and documented.

Approved: _____ Denied: _____

Human Resources Signature: _____ Date: _____

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