



FMLA/NJFLA FAMILY/MEDICAL LEAVE OF ABSENCE REQUEST FORM

Name: Last First MI Rowan ID: Ext:

Date of Hire: Email: Home phone:

Department: Supervisor:

I am requesting leave for the following time 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 a sick leave or personal leave of absence request as appropriate.

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

- () The birth of a child, or the placement of a child in my home for adoption or childcare
() 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's definition of "family" includes a parent-in-law or a stepparent, children of any age, siblings, grandparents, grand children, domestic partners, individuals related by blood, individuals with whom you have the equivalent of a family relationship)
Please provide name of family member

Please attach the appropriate documentation (i.e. birth certificate, adoption certificate, foster care court order.) 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

with pay using: Only earned sick vacation AL comp. time OR
with pay using: All earned/unearned sick earned vacation AL comp. time
without pay

If requesting a reduced hours or intermittent leave, please describe:

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

I understand that any false information give 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.

Employee Signature: Date:

To Supervisor and Department Head: Please sign and return the form to the Human Resources - Oak Hall. I am aware that the employee has requested a medical leave of absence and will ensure that all timesheets are properly coded (contact Payroll for proper leave codes). Please be advised that all medical documentation is submitted directly to the Office of Human Resources. Departments are not permitted to request or receive medical documentation from the employee.

Supervisor Signature: Date:

Dept. Head Signature: Date:

Dean Signature: Date:

This request for leave has been fully reviewed and documented. Approved Denied

HR/Benefits Office Signature: Date:

cc: Supervisor, Department Head
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