



FMLA/NJFLA FAMILY/MEDICAL LEAVE OF ABSENCE REQUEST FORM

Name: _____ Rowan ID: _____ Ext: _____

 Last First MI
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 "parent" includes a parent-in-law or a stepparent)
- 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.

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 - Bunce 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