

DATE: _____

TO: Human Resources

FROM: _____
Employee Name

_____ GEMS #

CC: _____
Supervisor

_____ Department

SUBJECT: Request for Leave – Family and Medical Leave Act (FMLA)

Reason for requested leave, in accordance with FMLA provisions:

- The birth of my child
- The placement of a child with me for adoption or foster care
- My serious health condition
- A family member in active military service (National Defense Authorization Act)
- A serious health condition affecting my:
 - Spouse _____
 - Child _____
 - Parent _____

Start date or anticipated start date _____ End date or anticipated end date _____

I request the leave be:

- With pay, using accrued sick, annual or other leave on a continual basis
- Intermittent leave using accrued sick, annual or other leave

I understand by submitting a request for FMLA-designated leave I agree that:

- Medical certification from a physician or other qualified healthcare provider (using the appropriate Certification of Health Care Provider form) will be required for leave due to my serious health condition or the serious health condition of my spouse, child, or parent. I may be required to provide a fitness for duty certification upon return from leave.
- If approved, the leave will count towards my 12 weeks/480 hours of entitlement (which is tracked on a fiscal year basis).
- If the leave is to be with pay or intermittent leave, it is my responsibility to communicate with my supervisor to request and/or verify the type and number of hours of paid leave to be used.
- If the anticipated end date of my leave changes, it is my responsibility to communicate with my supervisor and Human Resources to request approval of the change.
- I am responsible for continuing payment of my employee share of insurance premiums.
- When requesting intermittent FMLA leave for planned medical treatment, I am obligated to schedule the treatment at a time that will not unduly disrupt my department's operations.
- I understand my treating healthcare provider may be contacted to clarify or authenticate my FMLA certification.
- Re-certification may be required every 30 days, unless a specific period of time is designated in the initial certification (re-certification may be requested after the period elapses).

Employee Signature

Date Signed

Mail to: Division of Human Resources
University of South Florida; Attention: FMLA
4202 East Fowler Avenue, SVC 2172
Tampa, FL 33620

Fax to: (813) 974-5227
Attention: FMLA