College of the Holy Cross
Family Medical Leave Act Request Form

Employee: ___________________________ Dept: ___________________________ Phone: ________________

Reason for Leave: (Please select from the list below)

☐ My own serious health condition
☐ Serious health condition of my:
  ☐ Child    ☐ Spouse    ☐ Parent
  Name: __________________________________________

☐ Birth of a child

☐ I am requesting an 8-week paid medical leave per the provisions of the maternity leave policy.

☐ I am requesting a one-week paid leave per the provisions of the paternity leave policy.

☐ Adoption of a child

☐ I am requesting an 8-week paid leave per the provisions of the adoption leave policy.

☐ I am requesting a one-week paid leave per the provisions of the paternity leave policy.

☐ Placement of a child for foster care

☐ Active Duty

Leave Duration:
Anticipated Date of Leave: ___________________________ Anticipated Date of Return: ___________________________

Certification:
If leave is due to either your serious health condition or that of your seriously ill child, spouse or parent, you must provide medical certification by a health care provider before or at the beginning of your leave. (If the need for leave is unexpected, certification should be provided as soon as you are able to do so.) The form U.S. Department of Labor’s Certification of Health Care Provider for Employee’s Serious Health Condition form can be found on the web at http://www.dol.gov/whd/forms/WH-380-E.pdf, or by contacting human resources.

Employee Acknowledgement:
1. I currently intend to return to work on the first work-day following the date my FMLA leave ends, if my qualified health care provider gives me medical clearance to do so.
2. If I accept employment elsewhere or become self-employed during my FMLA leave, I understand that my employment with the College may be terminated.
3. I understand I will not accrue holiday pay or accrue vacation, sick, or personal time while in an unpaid status with the College during my FMLA leave.
4. I understand that taking a FMLA leave disqualifies me from receiving a perfect attendance award (non-exempt status only).
5. I understand that my accrued, but unused vacation, sick or personal time may be applied to my FMLA leave at its start, unless my leave runs concurrently with a worker’s compensation leave.
6. If my absence is the result of a workplace injury which is covered by a worker’s compensation, the fact that my FMLA leave will run concurrently with my worker’s compensation leave will not negatively impact or affect my rights under worker’s compensation laws.

___________________________ ___________________________
Employee Signature Date

___________________________ ___________________________
Supervisor Signature Date

Return form to: Human Resources, PO Box HR, 1 College Street, Worcester, MA 01610
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