Southwestern University

Request for Family or Medical Leave

Request for Family or Medical Leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin.

Name____________________________________________ Date___________________
Department________________________________ Title________________________________

Status:  ☐ Full-Time  ☐ Part-Time  ☐ Temporary
Hire Date____/____/____   Length of Service__________________

I request Family or Medical Leave for one or more of the following reasons:

☐ Because of the birth of my child and in order to care for him/her.

   Expected date of birth___/___/___   Actual date of birth___/___/___

   Leave to start___/___/___   Expected return date___/___/___

☐ Because of the placement of a child with me for adoption or foster care placement.

   Leave start___/___/___   Expected return date___/___/___

☐ For a serious health condition that makes me unable to perform my job

   responsibilities. Please describe:_________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   Leave to start___/___/___   Expected return date___/___/___

* A physician’s certification may be required for leave due to a serious health condition.

☐ To care for my spouse, child, or parent, who has a serious health condition.

   Leave to start___/___/___   Expected return date___/___/___

☐ To care for an active member of the Armed Forces

   Leave to start___/___/___   Expected return date___/___/___

☐ Requested intermittent leave schedule (if applicable; subject to employer’s approval)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
Have you taken a family or medical leave in the past 12 months: □ yes □ no
If yes, how many work days?_____

I understand and agree to the following provisions:

- I have worked for my employer at least one year and at least 1250 hours in the previous 12 months.
- If I fail to return to work after the leave for reasons other than the continuation, recurrence or onset of a serious health condition that would entitle me to Medical Leave or other circumstances beyond my control, and if my employer requires it, I will be financially responsible for the medical and life insurance premiums the University paid while I was on leave.
- This leave will require the use of up to at least 75% of accrued sick leave and vacation leave, balance to be unpaid, or in the case of my own disability, payment may occur under the University’s disability insurance plan, if I am so covered.
- I may be required to exhaust my paid sick, personal or vacation leave as part of my 12 or 16 weeks of leave.
- After my 12 or 16 weeks of leave, if I do not return to work or contact my supervisor or manager on the date intended, it will be considered that I abandoned my job.

Employee Signature_______________________________ Date_____/_____/_____

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LEAVE APPROVAL

For full day leave:

Manager/Supervisor Signature__________________________ Date_____/_____/_____

Senior Staff Signature__________________________ Date_____/_____/_____

For intermittent or reduced day leave:

Manager/Supervisor Signature__________________________ Date_____/_____/_____

President’s Cabinet Signature__________________________ Date_____/_____/_____

Human Resources Signature__________________________ Date_____/_____/_____

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PAYROLL INSTRUCTIONS

□  With pay from ____/____/____ to ____/____/____

□  Without pay from ____/____/____ to ____/____/____