Print Form

SETON HALL UNIVERSITY
1 8 5 6

# FAMILY MEDICAL LEAVE
# EMPLOYEE LEAVE REQUEST FORM

Employee Name:_____

SHU ID#:_____ Date:_____

Job Title:_____ Supervisor: _____

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) and/or the New Jersey Family Leave Act (NJFLA) for up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons, and up to 26 weeks of unpaid, job-protected leave in a 12-month period to care for a covered family member who was seriously ill or injured during their active military service.

Submit this request form to you supervisor at least 30 days before the leave is to commence, when possible. When submission of the request 30 days in advance is not possible, submit the request form as early as is possible. The University reserves the right to delay or deny leave for failure to give appropriate notice when such delay/denial would be permissible under federal or state law. Refer to the Family Medical Leaves Policy for complete details.

## ELIGIBILITY

- Counting any periods of time that you worked for the University (whether they were consecutive or not), have you worked for the University for a total of 12 months or more? Yes ○ No ○
- During the past 12 months, have you worked at least 1,000 hours? Yes ○ No ○
- Have you previously received medical or family leave? Yes ○ No ○
  If yes, provide information below:

Date of leave: From _____ To: _____
Purpose of leave: _____
_____

- Have you taken any intermittent leave? Yes ○ No ○
- Have you taken time off from scheduled hours? Yes ○ No ○
  If "yes", provide details: _____

## REASONS FOR REQUESTING LEAVE:

I am requesting leave for the following reason [check one]:

- ☐ My own serious health condition
- ☐ Serious health condition of:
  - Spouse Name:_____
  - Child Name:_____
  - Parent Name:_____
- ☐ Birth of Child Expected delivery date is:_____
- ☐ Adoption or placement of a child for foster care
  - Child's Name: _____
  - Scheduled date of adoption or placement:_____

☐ A qualifying exigency arising out of active duty or notification of impending call to order to active duty in the armed forces in support of a contingency operation of:

- Spouse Name: _____
- Child Name: _____
- Parent Name:_____

☐ Recovery from a serious injury or illness suffered while on active duty in the armed forces of:

- Spouse Name: _____
- Child Name: _____
- Parent Name:_____
- Next of Kin Name:_____

I HAVE or HAVE NOT previously taken FMLA or NJFLA-protected leave for this reason [circle one].

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**DATES OF LEAVE REQUESTED**:

☐ I request leave from _____ to _____.

☐ I request intermittent leave according to the following schedule :_____
_____
_____

☐ I request a reduced schedule leave according to the following schedule:_____
_____

The total number of weeks/ days of leave that I request is _____

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**EMPLOYEE STATEMENT**

I certify that the statements made above are true and accurate. I understand that I have an obligation to respond to any questions from the University designed to determine whether my absence is potentially FMLA and/or NJFLA qualifying. Furthermore, I understand that if I fail to respond to any reasonable inquiry by my employer regarding this leave request, the University may deny my leave request if the University is unable to determine whether the leave is FMLA and/or NJFLA qualifying.

Signature:_____ Date:_____

**Supervisor Approval**

Supervisor Signature:_____ Date:_____

Comments: _____

_____

**HR Approval**

HR Signature:_____ Date: _____

Comments: _____

_____