



Marshall University Research Corporation Human Resources

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REQUEST FOR FAMILY MEDICAL LEAVE OF ABSENCE

Under the provision of the Family Medical Leave Act (FMLA), this form is completed by the individual requesting FMLA leave before the leave commences. The employee understands that if leave is approved, time away from work will be charged against the 12 weeks maximum under FMLA. Upon approval of the requested leave, the employee can utilize all paid time available prior to going into an unpaid leave status. In the event that the employee goes into an unpaid status while on leave, the employee must contact Human Resources to make arrangements to pay their portion of health insurance premiums. This will serve as an agreement between Marshall University Research Corporation and the employee to continue benefits while on FMLA leave and a financial agreement for the employee portion of health care premiums.

- **Date:** _____
- **Employee Name:** _____ **MU ID:** _____
- **Preferred Email:** _____
- **College/Department:** _____
- **Supervisor:** _____

Request is made for leave with or without pay under the provisions of the federal Family Medical Leave Act (FMLA) and in accordance with Marshall University Research Corporation policy for the serious heal condition of:

Self Spouse Parent Child
OR
 Birth of Child Adoption of Child Foster Placement Military Leave

Do you plan to utilize paid time off (sick and annual leave) in conjunction with FMLA? Yes No

- *Current amount of available paid leave will be provided upon approval of FMLA. Please note that this amount may change based on usage and accrual from the time between approval and leave start date. It is the employee's responsibility to know the correct amount of paid time off available when leave begins and throughout FMLA leave*

A request for Family Medical Leave must be supported by having the healthcare provider complete the attached Healthcare Provider's Certification of Need for Family Medical Leave. Employee is responsible for ensuring the certification is received by Human Resources within 15 days.

Anticipated Leave Start Date: _____ **Anticipated Return from Leave Date:** _____

I understand that Family Medical Leave, if granted, may be used only for the purpose described above and that the use of such leave for any other purpose may result in disciplinary action, up to and including termination.

Employee Signature: _____ **Date:** _____

Note: *the employee, supervisor, and payroll will be notified by Human Resources whether or not Family Medical Leave is approved.*