UA LITTLE ROCK | DEPARTMENT OF HUMAN RESOURCES

Family and Medical Leave Act (FMLA) Request Form

Employee Name (Last, First, MI)	**Employee "T" Number**
Department	**Telephone Number**
Mailing Address	**Email Address**
Supervisor Name **Supervisor Email**	**Dean, Director or Department Head Name**
Requested FMLA Begin Date	**Requested FMLA End Date**

Please read and sign below:

- **I am requesting Family and Medical Leave (FMLA) for the dates shown above.**
- **I understand that FMLA, as federally mandated, is unpaid leave. University policy, however, requires concurrent use of accrued paid leave when such leave is available.**
- **I understand that the University will continue to pay the employer-matching portion of my group health, dental, basic life and basic long-term disability insurance premiums while I am on FMLA leave.**
- **I understand that I am responsible for paying the employee's portion of the premium each pay period and that if I do not, my insurance may be canceled after 30 days.**
- **I agree to return to work on the date listed under "Requested FMLA End Date". If circumstances change such that I will not be able to return to work on the date, I agree to inform my supervisor. (Physician's Release to Return to Work is required to return)**
- **I agree to submit the request form to my supervisor at least 30 days before the leave is to commence, when practicable. When submission on the request 30 days in advance is not practicable, I agree to submit the request as soon as possible.**
- **I understand that any employee who knowingly and/or purposefully provides false information in an attempt to gain approval of FMLA, abuses the use of approved FMLA leave for the purpose of monetary gain, recreational pleasures, or any such actions that are deemed contrary to the basic intent of the FMLA may be subject to disciplinary action, up to and including termination.**

I am requesting leave for the following reason:

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

☐ To care for a family member with a serious health condition

Spouse Name:_____

Child Name:_____

Biological Parent Name:_____

☐ Birth of a child (***expected delivery date***:_____)

(**Maternity FMLA ONLY**) ☐ I am requesting to be paid during this leave ☐ I am requesting to **NOT** be paid during this leave

☐ The placement of a child for adoption or foster care

☐ Military ☐ Care for Covered Service member ☐ Qualifying Exigency for Covered Service member

(Service member Name/Relationship:_____)

☐ Intermittent Leave Requested

☐ Reduced Schedule Requested (**Schedule Requested**:_____ _____)

Employee Signature	**Date**
Supervisory Signature	**Date**
Dean, Director or Department Head Signature (if required)	**Date**