COPPIN STATE UNIVERSITY
REQUEST FOR FAMILY AND MEDICAL LEAVE

EMPLOYEE INFORMATION

Name: **Employee ID:**	**Title:** **Department:**

Reason for requesting leave:

a. ☐ Birth of a child

b. ☐ Placement of a son or daughter for adoption/foster care.

c. ☐ Care for child, spouse, parent, or legal dependent with a serious health condition

d. ☐ Serious health condition which makes me unable to perform the functions of my position.

e. ☐ Servicemember Family Leave (up to 26 weeks)

If 3c is checked, please indicate: ☐ Child ☐ Parent ☐ Spouse ☐ Legal Dependent

Name and Address of Family Member: _____

_____

Effective Date of Leave Request:	**Date of anticipated return to work:**

Are you requesting leave on an intermittent or reduced work schedule? ☐ **Yes*** ☐ **No**

***If yes, please provide a certification from a health care provider justifying the necessity for intermittent leave. On a separate sheet give a schedule of when you anticipate you will be unavailable for work.

Employees seeking leave because of Reason c, d or e *must* have a health care provider complete the Certification of Health Care Provider Form and return it to the Office of Human Resources within 15 days, or as soon as practicable. Leave may be delayed until this form is provided. Employees seeking to return to work after a leave because of Reason 3d, ***also*** must complete the Return to Work Medical Certification Form before they will be allowed to resume work. Employees may not be permitted to resume any position until a completed Return to Work Medical Certification Form is provided.

EMPLOYEE AGREEMENT

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse my agency for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence, or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired, or that I am needed to care for a covered relative because he/she has a serious health condition on the date that my leave expired. I understand that while on FMLA leave, I will contact the Office of Human Resources after I have been on leave for 30 calendar days and at the end of each 30-day period afterwards.

Employee's Signature:_____ **Date:** _____

Supervisor's Signature:_____ **Date:** _____