Employee ________________

SOUTH PUGET SOUND COMMUNITY COLLEGE
REQUEST FOR FAMILY/MEDICAL LEAVE

Purpose of FMLA: An approved Family/Medical Leave (FMLA) protects eligible employees with the continuation of employer-paid health benefits and job restoration when employees have exhausted all paid leave and are in an unpaid leave status. Under FMLA, the employee is required to pay his/her portion of any health insurance premiums that are normally deducted from the employee's paycheck.

Instructions: Employees should use this form for all situations, such as; Family/Medical Leave with Parental Leave, Family/Medical Leave with Shared Leave, and Family/Medical Leave with Workers compensation (L & I). Please complete and submit this form to the Human Resources Office 30 days before planned absence or as soon as possible for unplanned absence.

Employees with serious health condition or an employee who has a family member with a serious health condition must have the Certification of Health Care Provider form completed by the Health Care Provider. To expedite receipt of the certification form, please suggest to your health care provider that the form may be faxed to the Human Resources Office at 360-596-5706.

Employees on an approved Family/Medical Leave will be required to complete and submit Leave Request form(s) to their supervisor or directly to the Human Resources Office in a timely manner.

(please print)

Name: ____
Employee ID #: ____
Current Position: ____
Work Location: ____
Telephone: Home:______________________ Office:____________________

I wish to request Family/Medical Leave (FMLA) beginning (date)_________________ and I expect to continue on such leave through (date) ___________________ for the following reason (select A or B) _________ (see list on page two of this request form).

If this request is due to a serious health condition, indicate date on which serious health condition commenced ____________________. Indicate probable duration of the condition: _______________
____

For Reduced Work Schedule or Intermittent Leave (complete this section if applicable):
Based on documentation from my health care provider, which I understand I must provide to Human Resources for serious health condition, I am requesting a reduced or intermittent work schedule as follows:
____
____.

Select one:

- ☐ **Option 1** – I wish to use and **exhaust all paid leave then begin unpaid FMLA Leave.** I understand that the counting of the 12-week FMLA entitlement will start after exhausting paid leave. I also understand that once I select this option, I cannot change it. I estimate that my paid leave balances will be exhausted and I will be in an unpaid leave status on (date) ____________________.
- ☐ **Option 2** – I wish to use paid leave during FMLA Leave. I understand that the counting of the 12-week FMLA entitlement will begin with paid leave. I also understand that once I select this option, I cannot change it.

Employee ________________

I understand that this request is subject to approval by the Chief Human Resources Officer. I also understand that determination of my eligibility requires compliance with the following 5 criteria:

(Do not write in shaded area)

1. Employee has worked a minimum of 1250 hours during the 12 months Immediately preceding the beginning of leave.

Instructors Only
Full-time faculty – has completed an annual contract of 43 – 48 credits/year (equivalent to hour minimum).
Part-time faculty – has completed 43 – 48 credits in preceding 12 month period (equivalent to hour minimum).
Specially funded faculty – has completed 220 day contract (equivalent to hour minimum).

2. Employee has worked a minimum of 12 months with the College. (52 weeks for part-time employees)

3. The absence is for one of the following reasons:

A — Employee's own serious health condition makes it impossible to perform essential job functions.

B — Employee is needed to care for the employee's child, spouse, or parent with a serious health condition.

4. Employee has or will provide required medical certification. **Failure to provide the fully completed Certification of Health Care provider form within 15 calendar days of the request may result in either the delay or denial of approval of the FMLA request.**

5. Employee has a balance remaining of "12 week FMLA leave entitlement" for the current year.

______________________________ ______________
Employee's Signature **Date of Request**