

SUNY POTSDAM REQUEST FOR LEAVE OF ABSENCE/FAMILY MEDICAL LEAVE

Name _____

Department _____ Title _____

Home Address _____

Home Phone _____ Line Number _____

I am requesting leave for the period Beginning (date) _____ Ending (date) _____

TYPE OF LEAVE BEING REQUESTED

_____ Leave With Pay _____ Workers' Compensation _____ Organ Donor

_____ Leave With Half Pay _____ Military _____ Bone Marrow Donor

_____ Leave Without Pay _____ Other, Please explain _____

Are you requesting leave under the Family Medical Leave Act?* _____ Yes (If yes, check all which apply) _____ No

I am requesting leave under the Family Medical Leave Act due to:

_____ A serious personal health condition that makes me unable to perform the essential functions of my job

_____ A serious health condition affecting my spouse, child, parent, for which I am needed to provide care

_____ The birth of a child or the placement of a child with me for adoption or foster care

_____ Military caregiver leave

_____ Qualifying exigency leave

***MEDICAL DOCUMENTATION MUST BE SUBMITTED TO HUMAN RESOURCES FOR ALL MEDICAL AND WORKERS' COMPENSATION LEAVES.**

Employee Signature

Date

Recommendation: Approve Leave Disapprove Leave

Supervisor's Signature

Date

Human Resources Use Only: Is employee eligible for FMLA? YES NO

Once Processed, copies to: ORIGINAL – Human Resources COPY 1 – Supervisor COPY 2 - Employee