Cape Fear COMMUNITY COLLEGE

Family and Medical Leave Request Form

EMPLOYEE INFORMATION (to be completed by the employee and returned to the supervisor)

First Name _____ Middle ____ Last Name _____ Employee ID # _____

Position _____ Department _____

Home Address _____

City _____ State ____ Zip Code _____ Home Phone _____

Classification ☐ Faculty ☐ Staff ☐ Other Contract Length ☐ 12 months ☐ 9 months ☐ Other

I am requesting Family and Medical Leave for the following reason:

- ☐ The birth of a child or placement of a child with me for adoption or foster care.
- ☐ My own serious medical condition.
- ☐ To care for my spouse, child or parent due to his/her serious medical condition.
- ☐ A qualifying exigency due to my spouse, child or parent is on or called to covered active duty in support of a contingency operation in a foreign country, as a member of the regular armed forces.
- ☐ I am the spouse, child, parent or next of kin of a covered service member with a serious injury or illness.

Requested duration of leave:

Date leave will begin _____ Expected date of return _____

☐ Continuous Absence ☐ Intermittent Absence

If you are requesting intermittent leave, please provide the details of the proposed leave schedule below.

_____

Is this request related to a current Workers' Compensation claim? ☐ Yes ☐ No

Have you submitted the Certification of Health Care Provider to Human Resources? ☐ Yes ☐ No

If you have not yet submitted the Certification of Health Care Provider, you will need to do so within 15 days or your request may be denied. The form is available online on the HR website or by contacting the Human Resources department at (910) 362-7312.

SIGNATURES:

Employee : _____ Date: _____

Supervisor: _____ Date: _____

Human Resources: _____ Date: _____