WAKE FOREST UNIVERSITY

Human Resources

REQUEST FOR FAMILY AND MEDICAL LEAVE

(Must be completed prior to the leave.)

EMPLOYEE INFORMATION	
NAME:	**WFU ID NUMBER:**
ADDRESS:	**DEPARTMENT:**
CITY/STATE/ZIP:	**SUPERVISOR:**

REASON FOR FML REQUEST	TYPE OF FML REQUEST
Please check one: ☐ *Maternity, Paternity, Adoption or Foster Care Placement* ☐ *Child, Spouse, or Parent Serious Health Condition ** ☐ *Employee Serious Health Condition ** ☐ *Qualifying Military Exigency ** ☐ *Covered Servicemember ** * Certification Form is required for approval	**Please check one:** ☐ *Continuous Leave* ☐ *Reduced Work Schedule ** ☐ *Intermittent ** * Physician recommendation is required for approval
BEGIN DATE OF REQUESTED LEAVE: / /	END DATE OF REQUESTED LEAVE: / /

Comments:

☐ I wish to continue my insurance coverage during FML ☐ Payroll Deduction ☐ Other
☐ I do not wish to continue my insurance coverage during FML

Employee Signature and Date:	Department Head Signature and Date:

USE OF ACCRUED PAID TIME OFF (PTO) DURING FAMILY AND MEDICAL LEAVE

In accordance with HRPPM, Section X-7, Family and Medical Leave, an employee must substitute any accrued paid time off (PTO) or Sick Leave (if applicable) for any unpaid Family and Medical Leave time, except that an employee may retain up to ten (10) days of PTO.

SEND TO: HUMAN RESOURCES DEPARTMENT, 116 REYNOLDA HALL
-OR-
FAX TO: ABSENCE MANAGEMENT SPECIALIST AT 336-758-6127

HUMAN RESOURCES DEPARTMENT USE ONLY

ELIGIBILITY	PREVIOUS FML TIME	NOTICE INFORMATION
☐ 12 months service? ☐ 1250 hrs worked / 12 months? ☐ Medical Certification complete? ☐ FML Approved? _____ weeks or _____ hours	Previous FML time used during last 12 month period? ☐ Yes ☐ No If yes: From: / / To: / / _____ for _____ week/hours	Date Received by Human Resources / /

ABSENCE MANAGEMENT COORDINATOR:	DATE: