ROGER WILLIAMS UNIVERSITY
REQUEST FOR FAMILY and MEDICAL LEAVE (FMLA)
For All Employees Except Facilities Management Employees

INSTRUCTIONS: Please complete the Family or Medical Leave Request form. Sign and date this form and return it to the Office of Human Resources.

Employee Name ***Social Security Number*** - -

Home Address: ***City & State*** ***Zip Code***

Position: _____ Department: _____ Telephone Number ( ) -

Supervisor: _____ Supervisor's Extension: _____

1. I request a FMLA for the following reason: (Check the appropriate box)

- ☐ A. Birth/Adoption/Foster Care Placement of Child (see #2.a. below)
  Name_____ Date of Birth/Adoption/Placement ____/____/____
- ☐ B. Care for Spouse/Parent/Child with Serious Health Condition (see #2.b. below)
  Name__ _____ Relationship_____ Birth Date ____/____/____
- ☐ C. Employee's Health Condition (see #2.b. below)

2. **a. If you are requesting for family leave in connection with birth, placement or adoption of a child,** you must attach the appropriate documentation to support the request (e.g. adoption papers or application for adoption, letter from adoption agency or lawyer, letter from doctor regarding impending delivery or copy of relevant medical record).

____ Appropriate documentation is provided.

b. If you are requesting family leave for the care of a family member or due to your own serious health condition, you must include a completed **U.S. Department of Labor Form WH-380Certification of Health Care Provider** form with the Request for Family Medical Leave of Absence Form. This form includes written certification of a licensed health care provider, stating the date on which the serious health condition commenced, the probable duration of the condition, and the appropriate medical facts entitling the employee to take leave. The certification must also include the amount of time the employee is needed to care for the family member or the employee is unable to perform the functions of the employee's job.

____ Medical Certification is provided.

3. **a. My leave will begin on ____/____/____ and end on ____/____/____ (not to exceed FMLA/RIPFLMA entitlement.)**

b. Date you plan to return to work _____/_____/_____

4. I am requesting the following type of leave: (Check the appropriate box)

- ☐ Continuous workweek (13 (or less) consecutive weeks).
- ☐ Intermittent Leave (taken in blocks of time).
- ☐ Reduction of Work Week.

5. My Intermittent or Reduced Work Week schedule will be as follows:

_____

_____

6. Substitution of Paid Leave: The following paid leave will run concurrently with unpaid FMLA leave, with the balance of the leave being unpaid FMLA leave. I authorize use of:

❑ _____Vacation Days (Enter zero if you DO NOT wish to use vacation days).

Per RWU policy, all accrued sick time will be used.

7. Benefit Continuation:

I understand that I am responsible for my regular employee payroll deduction for medical, dental and any voluntary insurance coverages during this FMLA leave whether I am in an unpaid or paid status. If I am in an unpaid status, then I understand that I must pay my regular employee benefit payroll deduction to the University and/or School of Law within 60 days of notification or my insurance coverage will be cancelled.

8. Conditions:

1. I will not accept other employment during the period of this leave.
2. If I do not return to work after this leave period expires my employment may be terminated, and I must pay any employee payroll deduction balance.
3. I will be re-instated in my former position, or a similar one, unless conditions have so changed that it will not be practical in the judgment of the University to do so.
4. I will provide appropriate medical certification as requested from the University.
5. I understand that in advance of my return date I need medical clearance to fully return to my position responsibilities.

9. Signature and Acknowledgment:

I certify as to the truth and accuracy of the information I provided on this form. This leave will count against any family or medical leave entitlement I may have in the State of Rhode Island. I have received a copy of the University's Family Leave Policy & Procedure.

I further understand that, if my leave is due to my own serious health condition or the care of a family member's serious health condition, I must submit Form WH-380 Certification of Health Care Provider form completed by the appropriate health care provider within 15 days and must submit updated Medical Certifications at the University's request.

_____ ____/____/____

Employee Signature ***Date***