

**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.

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*Employee Name* \_\_\_\_\_ *Social Security Number* - - -

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

*Position:* \_\_\_\_\_ *Department:* \_\_\_\_\_ *Telephone Number* ( ) -

*Supervisor:* \_\_\_\_\_ *Supervisor's Extension:* \_\_\_\_\_

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**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)

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**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-380 Certification 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.

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

**b. Date you plan to return to work \_\_\_\_/\_\_\_\_/\_\_\_\_**

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

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**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 Election:**

A. GROUP MEDICAL BENEFIT

- I elect to continue my medical coverage during FMLA leave.
- I elect to cancel my medical coverage during FMLA leave.

B. GROUP DENTAL BENEFIT

- I elect to continue my dental coverage during FMLA leave.
- I elect to cancel my dental coverage during FMLA leave.

I understand that I am responsible for the employee's share of premiums for coverage continued during FMLA leave.

**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 may be liable for the full benefit premiums paid on my behalf by the University.
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*