



# LAKE SUPERIOR STATE UNIVERSITY

## Request for Family Medical Leave (FML)

Employee's Name \_\_\_\_\_ Date Requested \_\_\_\_\_

My date of hire \_\_\_\_\_

My department and job title \_\_\_\_\_

My work location is \_\_\_\_\_

I  **have**  **have not** taken a leave of absence in the past twelve (12) months.

I  **have**  **have not** worked at least 1250 hours during the last twelve (12) month period immediately preceding my request for leave or the date on which the leave commences, whichever comes first.

I request a leave of absence for the following reason:

- To care for my child who was born on: \_\_\_\_\_
- Because I am adopting a child who will be placed with me on: \_\_\_\_\_
- Because a child is being place with me for foster care beginning on: \_\_\_\_\_
- To care for my spouse, child, or parent who has a serious health condition that began on: \_\_\_\_\_
- Because of a serious health condition that began on \_\_\_\_\_ and that renders me unable to perform the functions of my job.

I would like the leave to begin: \_\_\_\_\_

I expect to return to work on: \_\_\_\_\_

My address and telephone number during the leave will be:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
*Employee's Signature*

An eligible employee, upon request, may be granted up to twelve (12) work weeks of unpaid FML during any consecutive twelve (12) month period of employment.