

Stephen F. Austin State University

Family and Medical Leave Act of 1993

EMPLOYEE INFORMATION:

Name of Employee: _____

Employee ID: _____

Department: _____

Date HR was notified by employee: _____

Reason for Seeking Leave: _____

Type of Leave Requested: ☐ Continuous ☐ Intermittent FOR ☐ Self ☐ Dependent

Dates of Leave: _____

If seeking intermittent leave to work a reduced schedule, specify details: _____

ACKNOWLEDGEMENT:

I, _____, have requested a leave of absence from work that may be covered by the Family and Medical Leave Act, beginning on _____ (date).

I fully understand the following information:

- (1) This leave and any subsequent leave related to this condition will count against my annual leave entitlement under the Act. The FMLA policy contains all applicable entitlement limits to FMLA leave.
- (2) If my leave is being taken for my own serious health condition or because of the serious health condition of my spouse, parent, or child, I understand that I must provide medical certification to the University as soon as possible.
- (3) I have received a medical certification form from the University to give to my Health Care provider. I understand that if I do not provide the University with an accurate, complete medical certification in a timely manner my leave may be delayed until the University receives the certification or denied.
- (4) I understand that I will be required to continue my share of the Health Benefits Premium, which I have read and signed. The University may not increase or alter my insurance premiums why I am using FML.
- (5) I understand that if I take leave because of my own serious health condition, I will have to provide the University with a Fitness-for-Duty certification before I can return to work. The certification will pertain only to the condition that caused me to take FMLA leave.
- (6) I understand that at the end of my leave, I have the right to be restored to the same or an equivalent job.
- (7) I understand that FMLA policy requires me to contact my department on every Monday (unless otherwise agreed upon), and HR on the first and third Monday of each month.
- (8) I understand that if I have any further questions about leave under the FMLA, I may contact HR @ Human Resources, (936) 468-2304.

Employee Signature

Date



STEPHEN F. AUSTIN STATE UNIVERSITY

THE UNIVERSITY OF TEXAS SYSTEM • NACOGDOCHES, TEXAS

Human Resources

P.O. Box 13039, SFA Station • Nacogdoches, Texas 75962

Phone (936) 468-2304 • Fax (800) 435-3919 • Email hr@sfasu.edu

Family and Medical Leave

Certification of Placement/Bonding Leave Due to Adoption or Foster Care

EMPLOYEE INFORMATION (to be completed by the employee):

Employee's Name _____

Child's Name _____

Qualifying event for which bonding leave is being requested:

_____ Adoption

_____ Foster Care

PROVIDER CERTIFICATION (to be completed by the professional provider):

Adoption or Foster Care

I hereby certify that placement was made to the above named employee's family on:

_____ (Date of Placement)

(Print Name of Social Service Agency)

(Telephone Number)

(Social Service Agency Official's Signature)

(Date)

Please attach a copy of official placement documentation/certification.