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 or denied until the University receives the certification.

(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 while 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 Human Resources at ext. 2304.

_____ _____

Employee Signature Date

Certification of Health Care Provider for Family Member's Serious Health Condition under the Family and Medical Leave Act

SFASU Human Resources Department
936.468.2304office/936.468.1104 fax
email: hr@sfasu.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.
RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2026

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First Middle Last

(2) Employer name: _____ Date: _____ (mm/dd/yyyy)
(List date certification requested)

(3) The medical certification must be returned by _____ (mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18

☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include in loco parentis relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: _____

(3) Briefly describe the care you will provide to your family member: (**Check all that apply**)

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation

☐ Physical Care ☐ Psychological Comfort ☐ Other: _____

(4) Give your **best estimate** of the amount of leave needed to provide the care described:

_____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy), I am able to work _____ (hours per day) _____ (days per week)

Employee Signature _____ **Date** _____ (mm/dd/yyyy)

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider's name: (Print) _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) Patient's Name: _____

(2) State the approximate date the condition started or will start: _____ (mm/dd/yyyy)

(3) Provide your **best estimate** of how long the condition lasted or will last: _____

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).

_____

Employee Name: _____

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: (e.g. outpatient surgery, strep throat)

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for more than three consecutive, full calendar days from: _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

The patient (☐ was / ☐ will be) seen on the following date(s): _____

_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy).

☐ **Chronic Conditions**: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis)

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine if the benefits and protections of the FMLA apply.

(7) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s): _____

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) _____

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy). for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

_____

Employee Name: _____

(9) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy). for the period of incapacity.

(10) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day ☐ week ☐ month) and are likely to last approximately _____ (☐ hours ☐ days) per episode.

Signature of Health Care Provider _____ Date: _____ (mm/dd/yyyy)

Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

Policy Number: 03-501
Last Revised: N/A

Family and Medical Leave

Purpose

This policy explains who is eligible for family and medical leave and defines related terms. It also provides information for employees who may need to request family and medical leave.

Persons Affected

This policy affects for employees who may need to request family and medical leave.

Definitions

Applicable Paid Leave: Sick leave and vacation accruals.

Spouse: Those recognized as spouses by the State of Texas.

Parent: Includes biological parents and individuals who act as the employee's parents, but does not include parents-in-law.

Child/Son or Daughter: Legally recognized, including biological, adopted, foster children, stepchildren, and legal wards, who are under eighteen (18) years of age or eighteen (18) years of age or older and incapable of self-care because of mental or physical disability. For purposes of qualifying exigency leave, an employee’s son or daughter on covered active duty refers to a child of any age.

Serious Health Condition: Any illness, injury, impairment, or physical or mental condition that involves: (1) any incapacity or treatment in connection with inpatient care; (2) any incapacity or treatment requiring absence of more than three calendar days and continuing treatment by a health care provider; or, (3) continuing treatment by a health care provider of a chronic or long-term condition that is incurable or will likely result in incapacity of more than three days if not treated.

Continuing Treatment: Includes: (1) two or more treatments by a health care provider; (2) two or more treatments by a provider of health care services (i.e., physical therapist) on referral by or under orders of a health care provider; (3) at least one treatment by a health care provider which results in a regimen of continuing treatment under the supervision of the health care provider (i.e., a program of medication or therapy); or, (4) under the supervision of, although not actively treated by, a health care provider for a serious long-term or chronic condition or disability which cannot be cured (i.e., Alzheimer's or severe stroke).

Health Care Provider: Includes: licensed medical (MD) and osteopathic (OD) doctors, podiatrists, dentists, clinical psychologists, optometrists, chiropractors authorized to practice in the State, nurse practitioners and nurse-midwives authorized under state law, and Christian Science practitioners.

Needed To Care For: Encompasses: (1) physical and psychological care for a family member; and, (2) where the employee is needed to fill in for others providing care or to arrange for third party care of the family member.

Unable to Perform the Functions of the Employee's Job: Describes when an employee is (1) unable to work at all; or, (2) unable to perform any of the essential functions of their position. The term "essential functions" is borrowed from the Americans with Disabilities Act (ADA) to mean "the fundamental job duties of the employment position," and does not include the marginal functions of the position.

Qualifying Exigencies: Describes situations arising from the military deployment of an employee's spouse, son, daughter, or parent to a foreign country. Qualifying exigencies for which an employee may take FMLA leave include issues arising from the military member's short notice deployment; or making alternative child care arrangements for a child of the military member when the deployment of the military member necessitates a change in the existing child care arrangement; attending certain military ceremonies and briefings; attending counseling for the employee, the military member, or the child of the military member; or taking leave to spend time with a military member on Rest and Recuperation leave during deployment; or making financial or legal arrangements to address a covered military member's absence; or certain activities related to care of the parent of the military member while the military member is on covered active duty; or any other event that the employee and employer agree is a qualifying exigency.

Short Notice Deployment: Deployment within seven or less days of notice.

Covered Servicemember: A current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness. "Covered servicemember" also includes veterans discharged under conditions other than dishonorable within the five-year period before you first take military caregiver leave to care for that veteran. A serious injury or illness is one that is incurred by a servicemember in the line of duty on active duty that may cause the servicemember to be medically unfit to perform the duties of their office, grade, rank, or rating. A serious injury or illness also includes injuries or illnesses that existed before the servicemember's active duty and that were aggravated by service in the line of duty on active duty.

Policy

Employees are eligible to take family and medical leave within any 12-month period and be restored to the same or an equivalent position upon return from leave, provided that the employee has worked for the state of Texas for at least twelve (12) months and for at least 1,250 hours within the previous twelve (12) month period. Leave without pay may begin after all available applicable paid leave has been exhausted and will be included in the twelve (12) weeks of Family and Medical Leave Act (FMLA) time. Applicable Sick Leave Pool benefits, donated sick leave, and leave resulting from Workers' Compensation claims (See SFA HOP 03-220 Workers Compensation Insurance Coverage) will be included in the twelve (12) week period.

A. Reasons for Family and Medical Leave

Eligible faculty and staff may take up to 12 workweeks of leave in a 12-month period of family and medical leave for any of the following reasons:

1. The birth of a child or placement of a child with the employee for adoption or foster care;
2. To care for a spouse, child, or parent who has a serious health condition;
3. For a serious health condition that makes the employee unable to perform the essential functions of his or her job; or
4. For any "qualifying exigency" arising out of the fact that a spouse, son, daughter, or parent is a military member on covered active duty or has been notified of an impending call to covered active duty status.

Eligible faculty and staff may take up to 26 workweeks of leave in a 12-month period of family and medical leave for the following reason:

1. To care for a covered servicemember with a serious injury or illness, when the employee is the spouse, son, daughter, parent, or next of kin of the servicemember.

For purposes of FMLA, a rolling twelve (12) month period will be measured backward from the date leave begins.

Leave because of birth of a child or placement of a child with the employee for adoption or foster care must be completed within the twelve (12) month period beginning on the date of birth or placement. An employee is allowed to use sick leave for the period of time that is certified by the physician to recover from childbirth. An employee may take additional time off before returning to work requesting up to 12 weeks of leave for the birth or placement of a child under FMLA. However, the employee may not use sick leave for the remaining time unless the employee or the child is actually sick. In addition, spouses employed by Stephen F. Austin State University who request leave because of these reasons or to care for an ill parent may only take a combined total of twelve (12) weeks during any twelve (12) month period.

Sick leave may be used in conjunction with FMLA leave when a child under the age of three is adopted regardless of whether the child is actually sick at the time of adoption. Furthermore, an employee, who is the father of a child, may use his sick leave in conjunction with the child's birth only if the child is actually ill, or to care for his spouse while she is recovering from labor and delivery.

Employees with less than 12 months of state service and/or less than 1,250 hours of work in the 12 months immediately preceding the start of leave are entitled to a parental leave of absence, not to exceed 12 weeks (480 hours). The employee must first use all available and applicable paid vacation and sick leave while taking parental leave prior to going on leave without pay. Such parental leave may only be taken for the birth of a natural child or the adoption or foster care placement with the employee of a child under three years of age. The leave period begins with the date of birth or the adoption or foster care placement.

Procedures

A. Notice of Leave

If the need for family and medical leave is foreseeable, the employee must give thirty (30) days prior written notice. If this is not possible, the employee must give notice within one to two working days of learning of the need for leave or as soon as practicable. Failure to provide such notice may be grounds for delay of leave. Where the need for leave is not foreseeable, the employee is expected to notify the supervisor and Human Resources within 1 to 2 working days of learning of the need for leave, except in extraordinary circumstances. Requests for Family and Medical Leave forms are available from Human Resources. Employees should use these forms when requesting leave.

B. Medical Certification

If an employee is requesting leave because of their own or a covered relation's serious health condition, the employee and the relevant health care provider must supply appropriate medical certification. Medical Certification Forms may be obtained from Human Resources. The form must be returned to the director of human resources or a designated leave administrator within fifteen (15) days after the date leave is requested. Failure to provide requested medical certification in a timely manner may result in denial of leave until the certification is provided. The university, at its expense, may require an examination by a second health care provider designated by the university. If the second health care provider's opinion conflicts with the original medical certification, the university, at its expense, may require a third, mutually agreeable, health care provider to conduct an examination and provide a final and binding opinion. The university may require subsequent medical re-certification on a reasonable basis.

C. Reporting While on Leave

If an employee takes FMLA leave because of a personal serious health condition or to care for a covered relation, the employee must contact the supervisor at least once each week, or as often as requested by the supervisor, regarding the status of the condition and the intention to return to work. The supervisor is responsible for reporting this information to the leave administrator. Additionally, the employee is required to call Human Resources on the 1st and 3rd Monday of each month during their leave to report their leave and/or return to work status. Failure to communicate with the supervisor and Human Resources on the approved reporting schedule may result in denial of leave.

D. Leave Is Unpaid

Family and medical leave is unpaid leave after vacation, sick and all other applicable leaves have been exhausted. Employees may apply for sick leave from the Sick Leave Pool, which, if approved, will be included within the FMLA period. Employees may be eligible for short or long-term disability payments and/or workers' compensation benefits under the provisions of those plans. This leave time will also be included in the twelve (12) week period of FMLA. The use of applicable paid leave time does not extend the twelve (12) week leave period.

E. Medical and Other Benefits

During an approved family and medical leave, the university will maintain the state contribution for the employee's health benefits as if the employee continues to be actively employed. During periods of paid FMLA leave, the university will deduct the employee's portion of the insurance premiums as a regular payroll deduction. If the employee's FMLA leave is unpaid, the employee portion of the premium must be paid by the employee through the benefits personnel in Human Resources. The employee's insurance coverage will cease if the premium payment is more than thirty (30) days late. If the employee elects not to return to work at the end of the FMLA leave period, the employee will be required to reimburse the university for the cost of the premiums paid by the university for maintaining coverage during the leave, unless the employee cannot return to work because of a serious health condition or other circumstances beyond the employee's control. An employee on FMLA leave is not entitled to accrue state service credit for any full calendar months of leave without pay taken while on FMLA leave and does not accrue vacation or sick leave for such months of leave without pay.

F. Intermittent and Reduced Schedule Leave

Leave because of a serious health condition may be taken intermittently (in separate blocks of time due to a single health condition) or on a reduced leave schedule (reducing the usual number of hours worked per workweek or workday), if medically necessary. A reduced schedule is subject to availability depending on the business need of the department or the university. If leave is unpaid, the university will reduce the employee's salary based on the amount of time actually worked. In addition, while the employee is on an intermittent leave or reduced schedule, the university may temporarily transfer the employee to an alternative position which better accommodates recurring leave and which has equivalent pay and benefits.

G. Returning from Leave

If the employee takes leave because of a personal serious health condition, the employee is required to provide a release to return to work to their supervisor and the leave administrator that states that the employee is fit to resume work. An example of a release to return to work may be obtained from Human Resources. Employees failing to provide an acceptable release to return to work will not be permitted to resume work until it is provided.

Related Statues or Regulations, Rules, Policies, or Standards

The Family and Medical Leave Act of 1993 (FMLA), 29 C.F.R. § 825

Tex. Gov't Code § 661.912

SFA HOP 03-220 Workers Compensation Coverage

Responsible Executive

Vice President for Finance and Administration, Director of Human Resources

Forms

Family and Medical Leave Request for Leave Form, Certification of Health Care Provider for Employee's Serious Condition under the Family and Medical Leave Act, Certification of Health Care Provider for Family Member's Serious Health Condition under the Family and Medical Leave Act, Certification for Serious Injury or Illness of a Current Servicemember for Military Caregiver Leave under the Family and Medical Leave Act, Certification for Military Family Leave for Qualifying Exigency under the Family and Medical Leave Act, Family and Medical Leave Certification of Placement/Bonding Leave Due to Adoption or Foster Care.

Revision History

September 1, 2023 (original)