

# 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 John Wyatt @ Human Resources, ext. 4075.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date



# STEPHEN F. AUSTIN STATE UNIVERSITY

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## Human Resources

P.O. Box 13039, SFA Station · Nacogdoches, Texas 75962-3039

Phone (936) 468-2304 · Fax (936) 468-1104

## Family and Medical Leave

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

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### 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

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### 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.***