



# FAMILY AND MEDICAL LEAVE REQUEST FORM

(For GTRI Employees Only)

This section to be completed by employee:

\_\_\_\_\_ EID #

Employee Name: \_\_\_\_\_ Manager /Supervisor: \_\_\_\_\_

Department: \_\_\_\_\_ Dept. HR Rep: \_\_\_\_\_

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to up to 12 weeks of job-protected leave for certain family and medical reasons. Submit this request form to your supervisor or department head at least 30 days before the leave is to commence, when possible. When submission of the request 30 days in advance is not possible, submit the request as early as is possible. The employer reserves the right to deny or postpone leave for failure to give appropriate notice when such denial/postponement would be permitted under federal or state law.

1. Counting any periods of time you worked for the University System of Georgia, University System office (whether they were consecutive or not), have you worked for a total of 12 months or more? (If "yes," continue to question 2. If "no," stop here. Sign and submit this form to your supervisor or department head.) Yes No

2. During the past 12 months, have you worked at least 1,250 hours (approximately eight months of 40-hour weeks or one year of 25-hour weeks)? (If "yes," continue to question 3. If "no," stop here. Sign and submit this form to your supervisor or department head.) Yes No

3. Have you previously received medical or family leave? Yes No  
If yes, provide dates of Leave \_\_\_\_\_ to \_\_\_\_\_.

Reason for Leave:

4. Have you taken any intermittent medical leave? Yes No

5. Have you taken time off from scheduled hours? Yes No

If "yes," provide details:

6. Is your spouse employed by the University System of Georgia, University System Office? Yes No

If "yes," spouse's name: \_\_\_\_\_

Leave must be granted for any of the following reasons:

- For a serious health condition that prevents you from performing the duties of your job.
- To care for your child, spouse, or parent who has a serious health condition.
- To care for your child after birth, or for placement after adoption or foster care.

I request leave for the following reason:

Personal serious health condition

Serious health condition of: Spouse Child Parent

Birth of a child

Adoption or placement of a child for foster care

\_\_\_\_\_ Scheduled date of adoption or placement

