

**University of Maine System
Request for Family or Medical Leave**

Name: _____ Date: _____

I am requesting a Family and Medical Leave for the period starting _____ and ending _____.

I am requesting leave in the form of intermittent leave or reduced hours as follows (specify starting and ending dates and the hours to be taken as leave):

This leave is requested for:

____ Family leave: (check all applicable boxes and certification box if leave is being taken for a child):

____ Birth of a child

____ Care of a newborn child

____ Care of a child placed for adoption or foster care

____ Care of a family member with a serious medical condition:

(circle as appropriate: spouse, domestic partner, child, parent, sibling†)*

____ If leave is for a child, I certify that I am responsible for the daily care and/or financial support of the child.

____ My own serious medical condition

____ Military Family Leave because of a qualifying exigency (12 week maximum)

Attach [Certification of Qualifying Exigency for Military Leave form](#)

____ Military Family Leave to care for a covered servicemember with a serious injury or illness (26 week maximum) *Attach [Certification for Serious Injury or Illness of Covered Service member for Military Family Leave form](#).*

Anticipated leave balances (in hours) at beginning of leave:

Annual leave: _____. Disability leave: _____. Compensatory time: _____.

I will use accrued annual leave, disability leave (as allowed by University policy) and compensatory time for the period starting _____ and ending _____.

I will take leave without pay for the period starting _____ and ending _____.

I do ____ do not ____ wish to retain 40 hours of annual leave (*applicable if balance of 40 or more hours of annual leave has been accrued*)

* Leave to provide care for a domestic partner is covered under state law and requires completion of the Affidavit of Domestic Partnership (available at <http://www.maine.edu/pdf/DPForm.pdf>).

† An employee is eligible for family medical leave to care for a sibling if: a) the employee and sibling are jointly responsible for each other's common welfare as evidenced by joint living arrangements and joint financial arrangements, or b) the sibling is a member of the Armed Forces, including the National Guard and Reserves, and incurs a serious health condition or dies while on active duty.

If leave is for the care of a newborn child or a child placed for adoption or foster care, enter the date (or expected date) of birth or placement: _____

You may be required to show evidence of birth or placement for adoption or foster care. Family and Medical Leave may be used only in the first twelve months after birth or placement. After the twelve-month period any leave requested will be in accordance with policies for leave of absence without pay for personal reasons.

If leave is requested for the employee's serious medical condition or for care of a child, spouse, domestic partner, sibling, or parent with a serious medical condition, certification from a health care provider is required. The certification should be provided prior to the start of the leave or within 15 days of the leave request, whichever is later. If proper certification is not provided, the leave request may be denied or delayed.

I understand that group health and dental coverage will continue on the same terms as during active employment for any period covered by accrued paid leave. Group health and dental coverage will continue on the terms of active employment for up to a total of 12 weeks of federal FMLA leave, or 10 weeks for state FMLA leave, including paid and unpaid leave. Group health and dental coverage will continue on the terms of active employment for up to 26 weeks of FMLA leave for military caregiver leave. Accrued paid leave must be used prior to leave without pay except that one week of annual leave may be retained and an employee receiving Short Term Disability (STD) benefits may, but is not required, use accrued leave to supplement STD payments. After exhausting paid leave, I understand that any leave that extends beyond the FMLA limits (federal: 12 weeks; state: 10 weeks; military caregiver: 26 weeks) will be considered leave for personal reasons and I will be responsible for the full cost of group health and dental coverage.

At the end of a Family and Medical Leave, I understand that I may return to the job I held prior to the leave or an equivalent job. If the total leave exceeds 12 weeks (or 26 weeks for military caregiver leave) and becomes a leave without pay for personal reasons, return rights shall be in accordance with policies for leave without pay for personal reasons.

If leave is requested in the form of intermittent leave or reduced hours, it is my responsibility to schedule leave so as to not unduly disrupt University operations, to the extent that is medically feasible. If leave is in the form of intermittent leave or reduced hours, I understand that I may be reassigned to an equivalent job for the period of the leave, if the position to which I am reassigned can better accommodate the leave.

Employee' signature: _____

Comments:

Immediate Supervisor: Signature: _____

Department Head: Signature: _____

Response from Human Resources:

Contact _____ at _____ to make arrangements to continue to make your share of the premium payment on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

_____ The leave is approved as a Federal Family and Medical Leave and will count as _____ (circle one) days/ weeks towards your (circle one) 12 week/26 week FMLA entitlement.

_____ The leave is approved as a State Family and Medical Leave and will count as _____ (circle one) days/ weeks towards your 10 week entitlement.

_____ The leave is tentatively approved as a Family and Medical Leave pending receipt of a Certification of Health Care Provider Form. You are required to furnish medical certification of a serious health condition. You must furnish certification by _____ (must be at least 15 days after you are notified of this requirement), or we may delay the commencement of your leave until the certification is submitted.

_____ You meet the eligibility requirements for taking FMLA leave. However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information : _____ by _____.

_____ The leave is not approved as Family and Medical Leave because _____.

Comments:

Human Resources or President’s Designee: Signature: _____

Please review the attached [FMLA Notice of Rights and Responsibilities](#) for other important information.

cc: Personnel File (without copy of medical certification)
 Campus Family and Medical Leave File

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