

**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:

- Birth of a child
- Caring for a newborn child
- Caring for a child placed for adoption or foster care
- Caring for a family member with a serious medical condition:
(circle as appropriate: spouse, domestic partner* child, domestic partner's child*, parent)
- My own serious medical condition

Anticipated leave balances at beginning of leave:

- Annual leave: _____ hours
- Disability leave: _____ hours
- Compensatory time: _____ hours

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 hours of annual leave available.*

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, domestic partner's child, or parent with a serious medical condition, certification from a health care provider is required and should be attached to this request. 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.

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

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. Accrued paid leave must be used prior to leave without pay except that one week of annual leave may be retained. After exhausting paid leave, any leave that extends beyond the FMLA limits (federal: 12 weeks; state: 10 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 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: _____

Reviewing Officer(s):

Signature: _____

Signature: _____

President's Designee:

_____ The leave is approved as a Federal Family and Medical Leave.

_____ The leave is approved as a State Family and Medical Leave.

_____ The leave is tentatively approved as a Family and Medical Leave pending receipt of medical certification.

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

Signature _____

Date _____

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