

## REQUEST FOR FAMILY & MEDICAL LEAVE (FML)

PLEASE PRINT

\_\_\_\_\_  
Last Name First Name Middle Initial BGSU ID

\_\_\_\_\_  
Street Address City State ZIP Code

\_\_\_\_\_  
Department Supervisor

\_\_\_\_\_  
Home Telephone Business Telephone Campus Email Address

Faculty FT PT Administrative Staff FT PT Classified Staff FT PT

**\*\* NOTE to EMPLOYEE – After completing below, read and sign the reverse side of this sheet and return to the Office Human Resources. Your request for leave must be supported by medical documentation which you have provided or will provide to OHR.**

I am requesting Family & Medical Leave (FML) from work at Bowling Green State University for the care of:

Self

Spouse/Same-Sex Domestic Partner (with Marriage Certificate) (Name) \_\_\_\_\_

Child (Name) \_\_\_\_\_ (Age) \_\_\_\_\_

Parent (Name) \_\_\_\_\_

Military Service member (Name) \_\_\_\_\_

Medical Reason for Leave Request: \_\_\_\_\_

**NOTE:** For Birth of Child – Does your Spouse work for BGSU Yes No, (If Yes, please include name next to spouse line)

I am requesting leave on: *(Check all that apply)* BEGINNING AND ENDING DATES MUST BE LISTED

a full-time basis beginning \_\_\_\_\_ through \_\_\_\_\_

a reduced work schedule\* from \_\_\_\_\_ through \_\_\_\_\_

an intermittent schedule\*\* between \_\_\_\_\_ through \_\_\_\_\_

\* I will work a regular weekly schedule with reduced hours. \*\*I will take occasional or regularly scheduled time off for appointments, therapy, etc.

You may take any or all of the following leave for FML. Please check all that you will use:

sick compensatory vacation unpaid

INSTRUCTIONS TO EMPLOYEE:

1. Notify your immediate supervisor regarding the need for Family & Medical Leave (FML).
2. Note the following reminders:
  - a. Leave of absence is authorized in accordance with the Federal Family & Medical Leave Act (FMLA) and the University's current paid and unpaid leave of absence policies and procedures as provided in the handbooks. FML runs concurrently with approved leaves; it is **NOT** provided **in addition to or separate from these leaves**.
  - b. The Office of Human Resources requests medical certification from your physician (*Certification by Health Care Provider*) in order to determine whether your requested absence(s) is FML related. Your failure to submit the requested medical certification form within a timely manner (see below) may delay approval of your leave request.
  - c. Full-time employees are eligible for up to 12 weeks of FML per 12 month rolling period (one year from the start day of leave); part-time employees are eligible for pro-rated leave based on the average number of hours per week they worked during the prior 12 months.
  - d. Employees who have worked for at least 1,250 hours during the 12 month period immediately prior to the request for FML are eligible for leave.
3. Complete form, sign, and date.
4. Submit form to the Office of Human Resources, 1851 N Research Drive, Bowling Green, OH 43403. If leave is **foreseeable** (i.e., planned surgery or pregnancy), the law requires a 30-day notification for leave. In case of an emergency or **unforeseeable** illness, (i.e., car accident, heart attack) contact the **Office of Human Resources at 419.372.8422** as soon as possible.

**EMPLOYEE ACKNOWLEDGEMENT: Please read and sign below.**

I have read the above information and:

1. I understand that **until my absence is approved as FML**, I must follow the procedure to call my supervisor on a daily basis.
2. If my leave is due to planned medical treatments/appointments, I agree to consult with my supervisor and my (or my family member's) health care provider to schedule my planned work absences so that they do not unreasonably and unduly disrupt the operations of my work unit;
3. I understand my absence from work is not approved as FML time until it has been approved by the Office of Human Resources (HR).
4. **I understand that my Bowling Green State University handbook applies to my absence(s) and that, if I fail to give advance notice to the Office of Human Resources of my absence in writing, my leave may not be approved as Family & Medical Leave (FML).**
5. I acknowledge that it is my responsibility to submit the request form for FML to the Office Human Resources no later than 30 days before my requested leave or as soon as I become aware of my need for leave.
6. I acknowledge that, if I am taking leave for purposes other than those set forth in my FML leave request, my absence(s) may not be approved under or protected by the Family & Medical Leave Act.

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

Date \_\_\_\_\_

**It is the employee's responsibility to ensure that this form is properly completed and returned to the Office of Human Resources prior to or within a maximum of 15 days of the beginning date of the requested leave.**