Washtenaw Community College

Request for Family and Medical Leave of Absence

Employee Name: _____

Position Title: _____

Department: _____

1.I request a leave of absence for the following reason:

_____ Serious health condition of the employee
_____ Serious health condition of spouse, child or parent
*Print name of the person*_____
_____ Qualifying exigency for Military Family Leave
_____ Serious injury or illness of covered service member

2. Type of leave requested:

_____ Continuous Absence
_____ Reduced Work Schedule (limited to serious health condition)
_____ Intermittent Leave (limited to serious health condition)
_____ Multiple days of Absence for Medical Treatment

Leave to begin (date) _____ and end (date) _____

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Health Care Provider Certification

A health care provider certification form must be completed and submitted within 15 days of the requested leave date. Upon review of the form, a determination will be made by the College to approve or deny leave.

If it is determined that the health care provider certification form is incomplete or insufficient, the employee will be notified and further documentation or clarification will be requested.

Washtenaw Community College may request a health care representative review the health care certification form and contact the health care provider to clarify the information on the form.

If the certification form is not completed or cannot be clarified, leave approval may be delayed or denied.

Please review and complete the back side of this form and return to HRM.

I certify that the information on this form is true, complete and correct.

I acknowledge that I have reviewed a copy of the Washtenaw Community College Guidelines on Family and Medical Leave Act.

I understand that leave may be used only for the purposes described above, and that my employment may be terminated if I do not provide medical certifications requested or if I do not return to work after my leave.

I understand that Washtenaw Community College may request a health care representative review the health care provider certification form and contact the health care provider to clarify the information on the form. *I may revoke this authorization at any time in writing by notifying Human Resources.*

Employee signature:_____ Date: _____

Patient signature):_____ Date:_____
(if other than employee)

Revised May 2009