THE CATHOLIC UNIVERSITY OF AMERICA

Office of Human Resources / 170 Leahy Hall, Washington, DC 20064
Office: 202-319-5050 / Fax: 202-319-5802

Request for Family and Medical Leave of Absence (FMLA)

Request for Family and Medical Leave of Absence

THE COMPLETED FORMS NEED TO BE SUBMITTED TO HUMAN RESOURCES
(Please see above for contact information)

FORM 1: ***Request for Family and Medical Leave of Absence Form*** –This form must be completed by the employee and should include details about the leave requested. All appropriate fields must be completed to ensure request is processed in a timely manner. Please make sure the requested dates on this form are consistent with the dates on Form 2.

FORM 2: ***Certification of Health Care Provider Form*** - This form includes written certification of a licensed health care provider, stating the date on which the serious health condition commenced, the probable duration of the condition and the appropriate medical facts entitling the employee to take leave.

If you are requesting FMLA…

- ***For a birth of a child, Form 1 and Form 2 must be completed.***
- ***For your own illness, Form 1 and Form 2 must be completed.***
- ***For placement or adoption of a child, please complete Form 1 and provide the appropriate documentation (e.g., adoption papers or application for adoption, letter from adoption agency or lawyer).***

FORM 1

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SECTION I – EMPLOYEE INFORMATION

Employee CUA ID#:	**Name :** (Last, First)
Employee Home Address: (Street, City, State, Zip)	
Work Phone #:	**Cell Phone or Home Phone #:**
Email Address: (Please provide best email to reach you on your leave)	
Job Title:	**Department:**
Supervisor Name:	**Supervisor Extension:**
Standard Work Schedule: For Staff Only ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat	**Total Hours Worked Daily:** _____

Type of Leave Requested: ☐ **Medical (Employee)** ☐ **Medical (Family Member)** ☐ **Special Military Leave**

The Certification of Health Care Provider Form (Form 2) **must support the following sections**

SECTION II – TYPE OF LEAVE REQUESTED (PLEASE SELECT ONE)

☐ **NON-INTERMITTENT / CONTINUOUS LEAVE OF ABSENCE**

Estimated length of time requesting for leave of absence: _____ **Weeks** _____ **Days**

FMLA Start Date (First Day of Leave):	**Estimated Date of Return to Work:**

☐ **INTERMITTENT LEAVE / REDUCED WORK SCHEDULE (If you select this, please explain in Section III below)**

FMLA Start Date (First Day):	**FMLA End Date:**

SECTION III – REASON FOR REQUESTED LEAVE

Employee Signature:	**Date:**

Modified 08/12/2014