



LAMAR INSTITUTE OF TECHNOLOGY

A Member of The Texas State University System

FAMILY MEDICAL LEAVE REQUEST FOR LEAVE FORM

1. Name (First, Middle, Last)	2. Position
3. Reason for Requested Leave A. Birth of a Child B. Placement of a child with employee for adoption or foster care C. To care for a spouse, child, parent ("covered relation") with a serious health condition D. My own serious health condition which makes me unable to perform the functions of my position E. A qualifying exigency arising because my spouse, son, daughter, or parent is on covered active duty or call to covered active duty status to address certain qualifying exigencies as a current member of the Armed Forces, including a member of the National Guard for the Reserves. F. To care for a covered service member or veteran with a serious injury or illness	
4. If C, E, or F, please check one of the following <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____	5. Name and Address of person indicated in #4
6. Date on which you wish to commence leave.	7. Date of anticipated return to work.
8. Are you requesting leave on an intermittent or reduced leave schedule?	9. If "yes" to #8, please give schedule of when you anticipate you will be unavailable for work.

I understand that I must have the appropriate certification form completed and returned to the Human Resources Office within 15 days. I understand that my leave may be delayed until I provide a completed certification.

I understand that if my leave is for my own serious health condition, I will not be able to return to work until my physician completes a return to work form.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse my employer for the cost of health benefits provided by the state during my leave, unless I fail to return to work because of the continuation, recurrence, or onset of a serious health condition.

Employee Signature

Date