UMASS **University of Massachusetts**

Family Medical Leave Act Request Form

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Employee Name _____ Employee ID _____
(Last) (First) (MI)

Department _____ Department ID _____

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I am requesting a leave of absence for the reason so designated and understand that the leave cannot exceed twel
weeks. It is my intention to return to work at the end of the leave period.

Requested Leave Dates

Leave Begin Date [Month Day Year] Leave End Date [Month Day Year]

Please check one in each category:

Leave Reason	**Leave Type**	**Time Requested**
☐ Birth or Adoption	☐ Continuous	_____
☐ Care of Child	☐ Intermittent	☐ Days
☐ Care of Parent	☐ Reduced Schedule	☐ Hours
☐ Care of Spouse		☐ Weeks
☐ Employee Illness		

I understand that I will be reinstated to my same position, or an equivalent position, with equivalent pay, benefits and other employment terms and conditions.

I also understand that failure to return from the approved Family and Medical Leave within the agreed upon timeframe may constitute a voluntary termination.

I have read the Family and Medical Leave policy and the other appropriate policy(ies) specific to my absence and am aware of my responsibilities.

LEAVE WILL BE PAID ONLY IF EMPLOYEE HAS SUFFICIENT AND APPROPRIATE ACCRUALS TO COVER PART OR AL OF THE ABSENCE.

Employee Signature ▸ _____ **Request Date ▸** _____

Supervisor/Department Head ▸ _____ **Date ▸** _____

Benefits Manager ▸ _____ **Date ▸** _____