SAVANNAH STATE UNIVERSITY

Family Medical Leave Act Request Form

After completing one year of employment at Savannah State University (SSU), FMLA entitles any SSU employee who worked at least 1,250 hours during the previous 12 months to take up to of twelve weeks of unpaid leave in any twelve month period for any of the reasons designated below. To request an FML leave, please submit this form along with the physician's Medical Certification form to Human Resources.

Employee Name: Date of Hire: Employee ID#:

Job Title: Department: Supervisor's Name:

FMLA Eligibility Questions:

1. Have you worked for the University System of Georgia or Savannah State University (consecutive or not) for a total of 12 months or more? If yes, continue to the next question, otherwise stop here, sign and submit this form to Human Resources. ☐ Yes ☐ No
2. During the past 12 months, have you worked at least 1,250 hours? If yes, continue to the next question, otherwise stop here, sign and submit this form to Human Resources. Yes No
3. Have you previously received family or medical leave? If yes, please provide the additional information below.
   a. Dates of leave _____ to _____
   b. Purpose of leave _____
4. Have you taken any intermittent medical leave within the past 12 months? ☐ Yes ☐ No
5. Have you taken time off from scheduled hours? If yes, provide additional details: _____
   _____
6. Is your spouse employed by Savannah State University or a University System of Georgia institution? If yes, please provide your spouse's name and the USG institution. _____
   _____

Reason for requesting family medical leave:

☐ Birth of a child (must provide physician certification form for employee)

☐ Placement of a child with the employee for adoption (must provide adoption documentation)

☐ Serious health condition which renders the employee unable to perform the duties of their job (must provide physician certification form for employee)

☐ Serious health condition of the employee's child, spouse and parent (must provide physician certification form for family member)

☐ Immediate Family Member has been called to Active Duty (must submit a copy of the orders)

☐ To care for an immediate family member who has been injured during active duty in the US Armed Forces. (Allowed to take up to 60 months of leave; must provide physician certification form for family member)

☐ Called in support of US operations for a qualifying exigency

Dates of leave requested: (Check the box(es) that apply)

I request family medical leave from _____ to _____

I request intermittent leave according to the following schedule: _____
_____

I request a reduced schedule according to the following schedule: _____
_____

Total number of days requested: _____

Anticipated Return to Work date: _____

Contact information while on leave:

Address: _____

Telephone Number: _____

E-mail address: _____

Employee Statement:

I understand that once I am not longer receiving a paycheck from Savannah State University, I will be billed for any portion for applicable benefit premiums. I also understand that it it my responsibility to remain in close contact with Human Resources and my supervisor concerning my return to work date. Failure to return to work on my designated date without an extension approval may be treated as a resignation.

Additionally, in order to return to work, I understand that I must either submit a completed return to work form that has been completed by my treating physician.

_____ _____

Employee Signature and Date Supervisor Signature and Date