AUGUSTA UNIVERSITY
FMLA LEAVE REQUEST FORM

After completing one year of employment at Augusta University (AU), FMLA entitles any 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 FMLA leave, please submit this form along with the physician's Medical Certification form to Human Resources.

Employee Name: _____ **Employee ID:** _____

Job Title: _____ **Supervisor:** _____

FMLA Eligibility Questions:

1. ☐ Yes ☐ No — Have you worked for Augusta University (or University System of Georgia) (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.*
2. ☐ Yes ☐ No — 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.*
3. ☐ Yes ☐ No — Have you previously received Family or Medical Leave? If yes, please provide the additional information below:

   Dates of leave: _____ to _____

   Purpose of leave: _____
4. ☐ Yes ☐ No — Have you taken any intermittent Medical leave within the past 12 months?
5. ☐ Yes ☐ No — Have you taken time off from scheduled hours? If yes, provide additional details: _____
   _____
6. ☐ Yes ☐ No — Is your spouse employed by Augusta University?
   If yes, please provide your spouse's name: _____

Reason for Requesting FMLA Leave:

☐ Birth of a Child (must provide DOL Physician Certification Form-Employee & Birth Certificate)

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

☐ Serious health condition of the employee, which renders the employee unable to perform the duties of their job
→ must provide DOL Physician Certification Form-Employee

☐ Serious health condition of the employee's child, spouse, and parent
→ must provide DOL Physician Certification Form- Family

☐ 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 DOL Physician Certification Form-Family

☐ Called in Support of US Operations for a qualifying exigencies

Dates of Leave Requested: (Check the box (es) that apply)

☐ I request FMLA 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: _____

Email Address: _____

Phone #: _____

Employee Statement:

I understand that the USG FMLA policy requires that I use any available paid accrued leave while on FMLA. I understand that once I am no longer receiving a paycheck from the Augusta University, I may be billed for my portion of applicable benefit premiums. I also understand that it is my responsibility to stay 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 Medical Evaluation (Return to Work) form or a written Medical release from my physician.

_____ _____

Employee Signature **Date**

_____ _____

Supervisor signature **Date**
