**PART I**

## REQUEST FOR FAMILY AND MEDICAL LEAVE OF ABSENCE

SUBMIT THIS REQUEST TO YOUR DEPARTMENT HEAD 15 DAYS IN ADVANCE OF LEAVE WHEN NEED IS FORESEEABLE. EMPLOYEES WHO HAVE WORKED FOR AT LEAST 975 HOURS DURING THE 12-MONTH PERIOD IMMEDIATELY PRIOR TO THE REQUEST FOR LEAVE ARE ELIGIBLE FOR LEAVE.

NAME:________________________SSN:______________________________

ADDRESS:__________________________________________________________
__________________________________________________________

DEPARTMENT:___________________________________HIRE DATE_______

**TYPE OF LEAVE REQUESTED**

____EMPLOYEE MEDICAL LEAVE OF ABSENCE*
____FAMILY MEDICAL LEAVE OF ABSENCE*
____LEAVE TO CARE FOR NEWBORN OR ADOPTED CHILD OR A CHILD
____PLACED (VIA STATE PROCEDURES) FOR FOSTER CARE

THE LEAVE REQUESTED WILL BEGIN ON______AND END ON________.

IF REQUEST IS FOR MULTIPLE DAYS OFF FOR RECURRING MEDICAL TREATMENTS, SPECIFY DATES REQUESTED:

**REASON FOR LEAVE**

____MY PERSONAL SERIOUS HEALTH CONDITION*
____BIRTH OF MY CHILD
____SERIOUS HEALTH CONDITION OF MY CHILD*
____ADOPTION OF A CHILD BY ME
____SERIOUS HEALTH CONDITION OF MY PARENT*
____SERIOUS HEALTH CONDITION OF MY SPOUSE*
____PLACEMENT (BY THE STATE) OF A CHILD WITH ME FOR FOSTER CARE

Employee Signature____________________________________________________

Reviewed by Dean/Dept Head___________________________________________

*You are required to furnish Human Resources with a complete Health Care Provider Certification Form by. Failure to do so may result in your request for FMLA leave being denied.

**Original-Human Resources, Copy to Employee, Department**

## INSURANCE PREMIUM RECOVERY & REIMBURSEMENT AGREEMENT

I certify by my signature that I have read and understand the following policy:

I acknowledge Tulane University's legal rights to recover and hereby agree to repay the cost of any premium paid by it to maintain my coverage in group insurance benefits during any period of unpaid leave under the following conditions:

1. I fail to return from leave at the expiration of the leave to which I am entitled; and
2. The reason I fail to return to work is not one of the following:

A. The continuation, recurrence, onset of a serious health condition that entitles me to leave to care for a child, parent or spouse with a serious health condition, or if I am unable to perform the functions of my position due to my own serious health condition; or
B. Other conditions beyond my control prevent me from returning.

Date Leave Expires:______________________________________________

Name (Print)__________________________________________
SS#_______________________________________________

Signature_______________________________________ Date___________

**Please sign and return to Human Resources along with Request for FMLA.**