



**Lehigh University Faculty and Staff
Family and Medical Leave Request Form**

CONFIDENTIAL

TO BE SUBMITTED DIRECTLY TO THE HUMAN RESOURCES OFFICE

To be used by the Human Resources Office Only.

Employee Name: _____

Lehigh ID or Social Security Number: _____

Department: _____

Supervisor or Department Chair: _____

I am requesting leave for the following reason(s):

Personal serious health condition, including pregnancy (certification required)

Serious health condition of family member (certification required):

My Spouse/Partner (Spouse/Partner's Name: _____)

My Child (Child's Name: _____)

My Parent (Parent's Name: _____)

Service Member (Service Member's Name: _____)

Service Member's Relationship to employee: _____

Birth of a child (Expected delivery date is: _____)

I am the primary care-giver for this child.

I am not the primary care-giver for this child.

Adoption or placement of a child for foster care

Child's Name: _____

Scheduled date of adoption or placement: _____

I am the primary care-giver for this child.

I am not the primary care-giver for this child.

Qualifying exigency due to active military duty or pending call or order to active duty of family member

Name of Service Member: _____

Relationship to Employee: _____

Dates of Leave Requested:

I request leave from _____ to _____.

I request intermittent leave according to the following schedule:

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

The total number of days of leave that I request is _____.

EMPLOYEE STATEMENT:

I agree to return to work on _____. If circumstances change such that I will not be able to return to work on that date, I agree to inform Human Resources and provide necessary documentation to support the change in return date.

I have read and understand the terms and provisions of the *Lehigh University Family Medical Leave Policies*.

Signature: _____ Date: _____

FOR HUMAN RESOURCES USE ONLY:

Employee: _____

Requested Dates of Leave: _____

Request Received: _____

Certification Required? Yes No Certification Received? Yes No

Employee eligibility criteria:

Classification: _____

Length of Service: _____

Hours worked in last 12 months: _____

Family or medical leave taken in last 12 months: _____

Family or medical leave available: _____

Does leave requested qualify as family or medical leave? Yes No

Determination made by: _____

Title: _____ Date: _____