

**NCF EMPLOYEE REQUEST FOR FAMILY/PARENTAL AND MEDICAL LEAVE**

Date:

To: \_\_\_\_\_

(Supervisor's Name)

From: \_\_\_\_\_

(Employee's Name)

Subject: Request for Family and Medical Leave

This is to request Family and Medical Leave. If approved, I understand that this period of leave will count toward the twelve (12) work weeks entitlement of the Family and Medical Act. **The twelve (12) month period for State University System employees is from July 1 through June 30 of each fiscal year.**

I wish the leave for the period of: Start Date: \_\_\_\_\_ Return Date: \_\_\_\_\_

I request the leave to be:

\_\_\_\_\_ With pay, using my accrued/earned leave

\_\_\_\_\_ Without pay

\_\_\_\_\_ Intermittent leave, with and without pay within a pay period

If paid or intermittent leave use:

\_\_\_\_\_ Sick leave - at the rate of \_\_\_\_\_ hours/biweekly

\_\_\_\_\_ Compensatory leave - at the rate of \_\_\_\_\_ hours/biweekly

\_\_\_\_\_ Annual leave - at the rate of \_\_\_\_\_ hours/biweekly

\_\_\_\_\_ Personal holiday

\_\_\_\_\_ All leave before **LWOP**

Reason for requested leave:

\_\_\_\_\_ The birth of a child; or

\_\_\_\_\_ The placement of a child for adoption or foster care; or

\_\_\_\_\_ My personal illness/serious health condition; or

\_\_\_\_\_ A serious health condition affecting my:

\_\_\_ Spouse \_\_\_ Child \_\_\_ Parent (for which I am needed to provide care)

I understand that medical certification from a physician or qualified health care provider may be required for leaves due to the serious health condition of the employee or the employee's spouse, child or parent. I also understand that I am responsible for continuing payment of my employee share of insurance premiums.

\_\_\_\_\_

Employee's Signature

Date

\_\_\_\_\_

Supervisor's Signature

Date