Family and Medical Leave (FMLA) Request Form

University of Central Oklahoma, Office of Human Resources
100 N University Drive, Box 207 Edmond, OK 73034
Fax: (405) 974-3827

Name: _____ *UCO* ID# _____

Home Address: _____
(City) (State) (Zip Code)

Home Telephone: _____ Work Campus phone: _____

Department Name: _____ Campus Box Number: _____

Supervisor's Name: _____

Timekeeper's Name: _____

When Family and Medical Leave is needed to care for a seriously ill family member or service member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if irregular leave or leave on a reduced work schedule is requested. Serious health condition does not include common cold, flu, earaches, upset stomach, headaches, (other than migraine), routine physicals or dental/eye examinations. **If leave is for a non-serious illness, do not complete this form**.

*****Is this a work related injury/illness?*** ☐ **Yes** ☐ **No**

Request is for: ☐ **Self** ☐ **Care for Family Member**

Relationship of family member: _____
(i.e. mother, father, children {a dependent child is defined by FMLA regulations as a biological, adopted, or foster child, a stepchild, or a child of which the employee stands in loco parentis who is either under 18 years of age OR is 18 years of age or older and "incapable of self-care because of a mental or physical disability at the time FMLA leave is to commence".} In-laws are not covered by the Family and Medical Leave Act; exceptions include when a person stands in loco parentis to the employee.)

☐ **To Care for a Covered Service Member**
☐ **For Qualifying Exigency for Military Family Leave**

Dates of FMLA Leave-
Estimated Start Date: _____ ***Estimated End Date*:** _____

Briefly Explain Duration and Frequency of Leave Anticipated:

_____

_____

_____

Type of Leave Requested: Full-Time ☐ Intermittent ☐

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If you go into an unpaid status during your leave: UCO will continue to pay its portion of your health benefits. You will be responsible for any employee-paid premiums.

I certify that I understand, agree to, and meet the requirements and conditions of the Family and Medical Act of 1993; revised in 2009. I authorize the appointing authority to obtain any necessary information regarding my request for family and medical leave.

Employee Signature Date

Return to: Benefits@uco.edu or Box 207