



Request For Family Medical Leave of Absence

Employees who have been employed with the college for at least twelve months and have worked at least one thousand two hundred and fifty (1,250) hours during the twelve month period immediately prior to the request for leave are eligible to apply for *Family Medical Leave of Absence*.

Print Name: _____

X ID #: _____

Department: _____

Title: _____

REASON FOR LEAVE

I request a Family Medical Leave of Absence for the following reason (check one box):

My personal serious health condition (Medical certificate required.)

NOTE: A doctor's release is required if you are returning from a medical leave of one week or longer.

Birth of my child (A doctor's release is required when you return to work.)

Adoption of a child by me (copies of official adoption papers required.)

Serious health conditions of my spouse, parent or child (medical certificate required.)

FMLA leave for military families (documentation required).

It is my intent to return to work on _____.

If request is for multiple days off for recurring medical treatments of a child, parent, or spouse, or for your own medical treatments, specify anticipated periods of absence.

The leave (or extension) requested will begin on _____ and will end on _____.

Signature of Requestor

Date

Supervisor/Dept. Head Signature

Date

Human Resources Signature

Date



FMLA Leave Certification Requirements

This request for Family and/or Employee Leave of Absence must be submitted thirty (30) calendar days before the expected start of the leave (if the leave is foreseeable).

Care of Child, Parent, or Spouse

To request leave for the care of a child, parent, or spouse with a serious health problem a certification from the health care provider who is treating my child, parent, or spouse will be provided before leave begins. The certification includes the following:

1. The date on which the condition commenced.
2. The probable duration of the condition.
3. The appropriate medical facts within the knowledge of the health care provider regarding the condition.
4. An estimate of the time needed to care for the individual involved (including any recurring medical treatment).
5. A statement that the condition warrants my participation to provide care.
6. The anticipated date of return to work.

Employee's Health Condition

To request leave for the care of any employee's personal serious health condition I have attached a certification from the health care provider who is treating my own serious health condition. The certification includes the following:

1. The date on which the condition commenced.
2. The probable duration of the condition.
3. The appropriate medical facts within the knowledge of the health care provider regarding the condition.
4. A statement that I am unable to perform the functions of my position due to my condition.
5. The anticipated date of return to work.

Intermittent Leave

Additional certification requirements for intermittent leave or for leave on a reduced leave schedule is attached in addition to the foregoing certifications from the health care provider involved. I have attached additional information from the health care provider as stipulated below:

- A. Leave for employee
 1. A statement of medical necessity for my intermittent leave or reduced leave schedule and the expected duration of the schedule.
 2. A listing of the dates of my planned medical treatment and the duration of the treatment(s).
 3. A statement indicating my intention to return to work if/when physically able.
- B. Leave to care for a son, daughter, spouse or parent.
 1. A statement attesting to the necessity of intermittent leave or reduced leave for me to provide care or to assist in their recovery.
 2. An estimate of the expected duration and schedule of my intermittent leave or reduced leave.

I certify by my signature that I have read and understand the Lake-Sumter Community College's certification policy.

Signature

X ID #

Print Name

Date

Human Resources Representative: _____



**Certification of Physician or Practitioner
(Family and Medical Leave Act of 1993)**

1. Employee's Name: _____

2. Patient's Name (if different than employee): _____

Describe medical facts to support FMLA certification:

3. Date condition commenced: _____

4. Probable duration of condition: _____

5. Regiment of treatment to be prescribed. Indicate general nature and duration of treatment, including referral to other provider of health, services. If it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day per week, include schedule of visits or treatment.

a. By Physician or Practitioner:

Name of Physician or Practitioner: _____ Date: _____

Signature of Physician or Practitioner: _____

Address:

Street City State Zip

Phone: _____ Fax: _____

Return to: Lake-Sumter Community College Tel: 352-365-3547
ATTN: Benefits Office Fax: 352-435-5045
9501 US Hwy 441
Leesburg, FL 34788