



Family & Medical Leave Act (FMLA) Procedures

Step 1: Notify HR and your immediate supervisor as soon possible after you realize FMLA is needed.

Step 2: Receive FMLA documentation from HR

HR will provide employee with Fact Sheet #28, Request for Family/Medical Leave form, Medical Certification Form, and a FMLA Leave Request Form.

Step 3: Request for FMLA Form

Complete the Request for Family/Medical Leave Form as soon as you become aware of an absence that may qualify under FMLA. The original form must be submitted to your supervisor and a copy to the HR Office. This form should be submitted at least 30 days (when possible) before the leave is to begin.

Step 4: Determine Eligibility

You should receive a determination of eligibility from Human Resources within 2 business days after the Request for Family/Medical Leave form has been submitted.

Note: You must be employed at least 12 months and have worked at least 1,250 hours during the previous 12 months.

Step 4: Medical Certification Form

After eligibility has been determined, take the Medical Certification Form to your attending physician or health care provider and have them complete the certification portion. Be sure you and your doctor sign and date the form. The certification form must be returned to HR within 15 calendar days of receipt. Failure to provide the certification may result in denial or and/or delay in taking leave.

Step 5: Lawson State Community College FMLA Leave Request Form

Complete the FMLA Leave Request form. Sign and date the leave request form and have your immediate supervisor approve the leave. Forward the leave form to HR for processing. This should be done prior to taking leave.

Lawson State Community College
Family and Medical Leave Request
(Family and Medical Leave Act of 1993)

Date: _____

This request must be submitted to your supervisor at least 30 days, when practicable, before the leave is to start.

Subject: Request for Family/Medical Leave

Employee's Name: _____ Title: _____
 Social Security #: _____ Supervisor: _____
 Hire Date: _____ Length of Service: _____
 Employee Status: Full Time: _____ Part Time: _____

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

The birth and care of my child

Expected delivery date: _____

Start date of leave: _____ Expected date of return: _____

The adoption of foster care placement of a child **(certified legal documentation must be provided)**

Start date leave: _____ Expected date of return: _____

A serious health condition that makes me unable to perform the essential functions of my job
(Documentation from a healthcare provider must be provided)

Start date of leave: _____ Expected date of return: _____

A serious health condition affecting my spouse or my child, or parent, for which I am needed to provide care **(medical documentation must be provided)**

Start date of leave: _____ Expected date of return: _____

A serious illness or injury sustained in the line of duty on active duty affecting your Spouse
 Child Parent for which you are needed to provide care for the service member.

A Spouse, child or parent is on active duty or has been notified of an impending call to active status

Employee has previously taken family medical leave

yes no If yes, total time taken: _____

Employee plans to take paid leave in addition to unpaid leave yes no

If yes, what type of leave? Sick Leave Annual Leave Personal Leave #Hours _____

I certify that the leave/absence requested above is for the purpose(s) indicated. I understand that I must comply with my employment agency's procedures for requesting leave/approved absence (and provide additional documentation, including medical certification, if required) and that falsification of information on this form may be grounds for disciplinary action, including removal. I have been employed with this company for at least 12 months and have worked at least 1,250 hours. My health benefits must be maintained during any period of unpaid leave under the same conditions as if I continued to work, and I must be reinstated to the same position or an equivalent job with the same pay benefits and terms of conditions of employment upon my return from leave. If I do not return to work following FMLA leave for a reason other than the continuation, recurrence or onset of a serious health condition which would entitle me to FMLA leave, or other circumstances beyond my control, I may be required to reimburse the company for their share of health insurance premiums paid on my behalf during my FMLA. I may elect to substitute accrued paid leave for unpaid FMLA Leave.

 Employee Signature

 Date