



**Family and Medical Leave Act
Military Leave of Absence Request and Notice Form**

EMPLOYEE INFORMATION		
Employee's Name:		Employee ID:
EMPLOYMENT TYPE		
<input type="checkbox"/> USPS	<input type="checkbox"/> Faculty	<input type="checkbox"/> A&P
<input type="checkbox"/> Executive Service	<input type="checkbox"/> OPS	
CONTRACTUAL PERIOD		
<input type="checkbox"/> 9 month	<input type="checkbox"/> 10 month	<input type="checkbox"/> 12 month
<input type="checkbox"/> Varied (OPS employees)		
EXPECTED DATES OF LEAVE		
<input type="checkbox"/> Continuous Leave	Begin Date: _____	End Date: _____
<input type="checkbox"/> Intermittent Leave	Begin Date: _____	End Date: _____
<input type="checkbox"/> Reduced Work Schedule	Begin Date: _____	End Date: _____
REASON FOR LEAVE REQUEST		
<input type="checkbox"/> A qualifying exigency due to the fact that your () spouse, () child, or () parent is on covered active duty or call to covered active duty with the Armed Forces.		
<input type="checkbox"/> To care for a covered service member or veteran with a serious injury or illness affecting your () spouse, () child, () or () next of kin.		
FMLA GUIDELINES		
I understand that if my spouse, parent, or child is deployed or has been notified of an impending deployment to a foreign county, I may be entitle to take up to a total of 12 weeks of FMLA leave during a single 12 month period. I understand that if my spouse, parent, child or next of kin has a serious injury or illness, I may be entitle to military caregiver leave and take up to a total of 26 weeks of unpaid FMLA leave during a single 12 month period.		
Employee's Signature:	Print Name:	Date:
SIGNATURES		
Supervisor's Signature:	Print Name:	Date:
Department's Head Signature:	Print Name:	Date:

