REQUEST FOR FAMILY AND MEDICAL LEAVE

Arkansas School for Mathematics, Sciences and the Arts

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| Employee Name (Last, First, MI) | Telephone Number | Date (mm/dd/yy) |
| Employee ID Number | Department |
| Supervisor Name | Employee Job Title |
| Requested FMLA Begin Date (mm/dd/yy) | Requested FMLA End Date (mm/dd/yy) |
| Please read and sign below:* I am requesting Family and Medical Leave (FMLA) for the dates shown above.
* I understand that FMLA, as federally mandated, is unpaid leave. Current state policy, however, requires substitution of accrued paid leave for FMLA time requests when such leave is available.
* I understand that the Arkansas School for Mathematics, Sciences and the Arts may require a written second opinion form a health care provider at the expense of the institution.
* I understand that, if approved for FMLA, the institution will continue paying the Employer portion of my group health insurance, if I am a participant. I understand that I am responsible for paying the Employee’s portion for the Health Plan for each pay period. If I do not pay, my Health Plan may be cancelled after 30 days.
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| Employee Signature | Date (mm/dd/yy) |

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| AUTHORIZATION (to be completed by HR personnel only): |
| Approval:   | [ ]  Approved | [ ]  Disapproved |
| Eligibility: | Employed 12 mo: [ ]  Yes [ ]  No | 1,250 hrs worked: [ ]  Yes [ ]  No |
| Approving Authority: |  |
| Date: |  |  |