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. | | |
| 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: |  | | |  |