USF UNIVERSITY OF SOUTH FLORIDA

Employee Request for FMLA Leave

Division of Human Resources
Phone (813)974-2970 / Fax (813)974-5227 / SVC 2172

Date:	/ /	**GEMS Employee ID:**	
Employee Name:		**Department:**	
Manager/Supervisor:		**Supervisor's Email**	
Please provide your preferred method for correspondence (email *or* complete home address):			

Reason for requested leave, in accordance with FMLA provisions:

- ☐ The birth of my child **
- ☐ Placement of a child with me for adoption or foster care **
- ☐ My serious health condition
- ☐ A serious health condition affecting my: ☐ Spouse ☐ Child ☐ Parent ** ☐ *In loco parentis*
- ☐ Military Caregiver ☐ Spouse ☐ Child ☐ Parent ☐ Next of Kin
- ☐ Military Exigency ☐ Spouse ☐ Child ☐ Parent ☐ Next of Kin

** **If FMLA is requested for birth/adoption or care of parent:**

☐ My spouse is a USF employee

Spouse's full name: _____

Start date or anticipated start date: _____ (mm/dd/yyyy)

End date or anticipated end date: _____ (mm/dd/yyyy)

I request the leave to be:

☐ **Continuous** - absence that is three days or longer in a single occurrence

☐ **Intermittent** - absence has periodic occurrences with time worked between absences.

I understand by submitting a request for FMLA-designated leave I agree that:

- Medical certification from a physician or other qualified healthcare provider (using the appropriate Certification of Healthcare Provider form) will be required for leave due to my serious health condition or the serious health condition of my spouse, child, or parent. I may be required to provide a Release to Return to Work form upon return from leave.
- If approved, the leave will count towards my 12 weeks/480 hours of entitlement. FMLA leave is tracked on a rolling 12-month period measured backward. Faculty covered under USF's United Faculty of Florida (UFF) Collective Bargaining Agreement (CBA) will be tracked on a fiscal year basis.
- If the leave is to be with pay or intermittent leave, it is my responsibility to communicate with my supervisor to request and/or verify the type and number of hours of paid leave to be used.
- If the anticipated end date of my leave changes, it is my responsibility to communicate with my supervisor and Human Resources to request approval of the change.
- I am responsible for continuing payment of my employee share of insurance premiums.
- When requesting intermittent FMLA leave for planned medical treatment, I am obligated to schedule the treatment at a time that will not unduly disrupt my department's operations.
- I understand my treating healthcare provider may be contacted to clarify or authenticate my FMLA certification.
- Re-certification may be required every 30 days, unless a specific period of time is designated in the initial certification (re-certification may be requested after the period elapses).
- Should HR not receive my completed documentation, and I remain absent from employment with USF, I understand that I may be subject to termination from my position, consistent with USF's policies and regulations regarding attendance and unexcused absences.

_____

Employee Signature Date

Mail to: Division of Human Resources
University of South Florida; Attn: FMLA
4202 E Fowler Ave., SVC 2172
Tampa, FL 33620

Fax to: 813-974-5227

Email to: FMLA@usf.edu