Delgado COMMUNITY COLLEGE

REQUEST FOR FAMILY AND MEDICAL LEAVE ACT (FMLA) LEAVE

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to take job-protected leave for certain family and medical reasons. Employees are eligible for FMLA leave if they have worked for at least one year, and for 1,250 hours over the previous 12 months. A FMLA leave of absence is a leave without pay; however, paid leave (accrued sick, annual and/or compensatory hours) may be substituted for the unpaid leave in accordance with LCTCS Policy #6.041, Family and Medical Leave for All Employees.

Directions: Submit this request form to the Office of Human Resources for processing at least 30 days before the leave is to begin, when possible. If not possible, please submit as soon as possible.

Name of Employee | Employee ID#

Job Title | Department

Name of Supervisor | Supervisor's Title

Mailing Address During Leave | City/State | Zip Code

Personal Phone Number | Personal Email Address

I am requesting FMLA Leave for this purpose:

- ☐ The birth of my child, or placement of a child with me for adoption or foster care;
- ☐ My own serious health condition;
- ☐ I am needed to care for my _____ (spouse) _____ (child) _____ (parent) due to his/her serious health condition;
- ☐ Other: _____

I am requesting FMLA Leave for these dates:

From: _____ (date) To: _____ (date)

I acknowledge that submission of this form does not imply that the leave will be approved. I understand that the approval of FMLA leave is subject to meeting eligibility qualifications as set forth by the U.S. Department of Labor.

_____ _____

Signature of Employee | Date

For HR Office Use Only: Received by HR Staff: _____ ***Date:*** _____