COLLEGE OF THE HOLY CROSS
Employee Application for leave of absence under the Family Medical Leave Act
(page 1)

Name: _____ Hire Date: _____

Position: _____ Date of Request: _____

Department: _____ Phone number: _____

Please check applicable boxes and then confirm your request, attestation, and employee acknowledgement with your signature:

1. I am requesting a leave under the Family Leave Medical Act (FMLA) for the (choose one):

☐ My own serious health condition

☐ Serious health condition of my child: _____ (print full name)

☐ Serious health condition of my spouse: _____ (print full name)

☐ Serious health condition of my parent: _____ (print full name)

2. Attestation (choose one if applicable):

☐ I am the parent of the child listed above

☐ I am legally married to the spouse listed above

☐ I am the child of the parent listed above

3. Anticipated dates of requested FMLA leave of absence:

Anticipated date of leave _____

Anticipated date of return _____

COLLEGE OF THE HOLY CROSS
Employee Application for leave of absence under the Family Medical Leave Act
(page 2)

4. Employee Acknowledgement:

a. I have notified my supervisor that I am filing for an FMLA leave.

b. I affirm that I intend to return to work at the College at the expiration of my leave.

c. I understand that my accrued, but unused vacation, sick, or personal time may be applied to my FMLA leave, unless my leave runs concurrently with a worker's compensation leave.

d. I understand that any deliberate misrepresentations made in this statement are punishable pursuant to the College's policies regarding misrepresentations by employees.

e. I certify that all of the statements made herein are true and accurate to the best of my knowledge and belief.

Employee Name: _____

Employee Signature: _____

Date: _____

Upon receipt of this application, Human Resources will provide you with the following information within five business days:

- **FMLA Notice of Eligibility**
  (legally required notice, there is no action required on your part other than to review this notice)
- **Certification of Health Care Provider** form
  (your health care provider's certification of the serious health care condition for you or your child, spouse, or parent – to be submitted to HR within 15 days of receipt)

You will receive an **FMLA Designation Notice** (written notification of approval or denial) within five business days of Human Resources having the required information to determine whether the leave is FMLA-qualifying.