



BOARD OF REGENTS OF
THE UNIVERSITY SYSTEM OF GEORGIA

UNIVERSITY SYSTEM OFFICE (USO)
FMLA LEAVE REQUEST FORM

After completing one year of employment at the University System Office (USO), FMLA entitles any USO employee who worked at least 1,250 hours during the previous 12 months to take up to of twelve weeks of unpaid leave in any twelve month period for any of the reasons designated below. To request an FMLA leave, please submit this form along with the physician's Medical Certification form to Human Resources.

Employee Name: _____ Date of Hire: _____

Job Title: _____ Supervisor: _____

FMLA Eligibility Questions:

1. Yes No Have you worked for the University System of Georgia, University System Office (consecutive or not) for a total of 12 months or more? *If yes, continue to the next question, otherwise, stop here. Sign and submit this form to Human Resources.*
2. Yes No During the Past 12 months have you worked at least 1,250 hours? *If yes, continue to the next question, otherwise, stop here. Sign and submit this form to Human Resources.*
3. Yes No Have you previously received Family or Medical Leave? If yes, please provide the additional information below:
Dates of leave: _____ to _____
Purpose of leave: _____
4. Yes No Have you taken any intermittent Medical leave within the past 12 months?
5. Yes No Have you taken time off from scheduled hours? If yes, provide additional details: _____
6. Yes No Is your spouse employed by the University System of Georgia, University System Office? If yes, please provide your spouse's name: _____

Reason for Requesting FMLA Leave:

- Birth of a Child (must provide DOL Physician Certification Form-Employee & Birth Certificate)
- Placement of a child with the employee for adoption (must provide adoption papers)
- Serious health condition of the employee, which renders the employee unable to perform the duties of their job (must provide DOL Physician Certification Form-Employee)
- Serious health condition of the employee's child, spouse, and parent (must provide DOL Physician Certification Form-Family)
- Immediate Family Member has been called to Active Duty (must submit a copy of the orders)
- To care for an immediate family member who has been injured during Active duty in the US Armed Forces. (Allowed to take up to 60 months of leave; must provide DOL Physician Certification Form-Family)
- Called in support of US Operations for a qualifying exigencies

Dates of Leave Requested: (Check the box(es) that apply)

I request FMLA leave from _____ to _____

I request intermittent leave according to the following schedule: _____

I request a reduced schedule according to the following schedule: _____

Total number of days requested: _____

Anticipated Return to Work date: _____

I understand that the USO FMLA policy requires that I use any available paid sick leave while on FMLA. Once I have exhausted my sick leave, I wish to:

Continue on paid FMLA using my accumulated vacation time, if available

Continue on unpaid FMLA and freeze any vacation time available

Contact Information while on leave:

Address: _____

Email Address: _____

Phone #: _____

Employee Statement:

I understand that once I am no longer receiving a paycheck from the University System Office, I may be billed for my portion of applicable benefit premiums. I also understand that it is my responsibility to stay in close contact with Human Resources and my supervisor concerning my return to work date. Failure to return to work on my designated date, without an extension approval, may be treated as a resignation.

Additionally, in order to return to work, I understand that I must either submit a completed Medical Evaluation (Return to Work) form or a written Medical release from my physician.

Signature

Date

Supervisor signature

Date
