



If you will go into an unpaid status during your leave and you want to avoid discontinuing your health insurance, indicate how you want to pay your share of the insurance premium:

- Prepayment by payroll deduction;
- Prepayment by personal check (overpayments will be refunded); or
- Payment by personal check – Bi-Weekly
- Does Not Apply

I certify that I understand, agree to, and meet the requirements and conditions of the Family and Medical Act (FMLA) of 1993; revised in 2009. I further certify that the information contained on this form is correct to the best of my knowledge. I authorize the FMLA Coordinator to obtain and verify any necessary information regarding my request for family and medical leave. I understand that providing incomplete or false information may result in disqualification of FMLA leave and or disciplinary actions up to and including termination of employment.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

***Return to: Libby Gilbert, FMLA Coordinator, Human Resources, Campus Box 15***

### Human Resources Use Only

Average Hours Worked per Week: \_\_\_\_\_ Forms Received Within Guidelines: \_\_\_\_\_

Employed 12 months & has worked 1250 hours in last 12 months: \_\_\_\_\_ Hire Date: \_\_\_\_\_

Physician Certification Received: \_\_\_\_\_ ADA accommodation requested: \_\_\_\_\_ Approved \_\_\_\_\_ Denied

From: \_\_\_\_\_ To/Thru \_\_\_\_\_ Intermittent \_\_\_\_\_

Revised: \_\_\_\_\_ Date: \_\_\_\_\_ Extended from: \_\_\_\_\_ To: \_\_\_\_\_

Military: \_\_\_\_\_ Date: \_\_\_\_\_ Extended from: \_\_\_\_\_ To: \_\_\_\_\_

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_