

**SALT LAKE COMMUNITY COLLEGE  
APPLICATION FOR FAMILY MEDICAL LEAVE**

Name: \_\_\_\_\_ S#: \_\_\_\_\_

Department: \_\_\_\_\_ Manager: \_\_\_\_\_

Current Address: \_\_\_\_\_

Start date of leave: \_\_\_\_\_

Expected date of return to work: \_\_\_\_\_

Reason for Leave (Explain): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Note:** A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child or parent must be accompanied by verifying medical certification from a qualified health care provider.

Provider Name: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

I hereby authorize any physician, counselor, psychologist, psychiatrist, vocational rehabilitation counselor, or social worker to furnish To discuss and consult with Salt Lake Community College, any information in their possession pertaining to the need for Family Medical Leave. By signing this release, I represent that I have read all the information on this page, understand it, and am in agreement with the authorization I now make. This authorization is valid for one year from the date signed below.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by the Human Resources Office.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Approval:**

Date Application Received: \_\_\_\_\_ Meets 12 months Requirement: \_\_\_\_\_

Date Medical Certification Received: \_\_\_\_\_ Meets 1250 Hour Requirement: \_\_\_\_\_

Date of confirmation letter: \_\_\_\_\_

Human Resources Approval: \_\_\_\_\_