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SALT LAKE COMMUNITY COLLEGE
APPLICATION FOR FAMILY MEDICAL LEAVE

Name: _____ **S#:** _____

Department: _____ **Manager:** _____

Mailing Address/Phone: _____

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, 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: (For HR use only)

Meets 12 months Requirement: _____

Date Application Received: _____

Meets 1250 Hour Requirement: _____

Date Medical Certification Requested: _____

Date Medical Certification Received: _____

Date of Eligibility letter: _____

Date of Approval letter: _____

Human Resources Approval: _____

Sick _____ **Vacation** _____