

**CLEMSON UNIVERSITY
FAMILY MEDICAL LEAVE ACT (FMLA)
REQUEST FORM
(To be completed by employee)**

Please print in black ink.

ALL BOLDED AREAS MUST BE COMPLETED

NAME _____ **EMPL ID** _____

MAILING ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

DEPARTMENT NUMBER _____ **DEPARTMENT NAME** _____

SUPERVISOR _____

PURPOSE OF LEAVE (Check one)

_____ **Employee's Personal Illness / Type of Illness** _____

_____ **Childbirth** _____ **Adoption** _____ **Foster Child** _____ **Anticipated date** _____

_____ **Care of Seriously Ill Family Member (Employee's Parent, Spouse, Child)**

-**Name of Family Member** _____ **Relationship** _____

-**Type of Care Required** _____

FMLA BEGINNING DATE _____ **FMLA ENDING DATE** _____

TYPE OF LEAVE TO BE USED DURING FMLA LEAVE (check all that apply).

- _____ *Sick Leave, if available, must be taken concurrently during the FMLA period for personal illness.*
- _____ *Annual Leave may be taken concurrently for any period of FMLA after eligible sick leave has been exhausted or for periods of FMLA that do not qualify for sick leave.*
- _____ *Family Sick Leave may be taken concurrently for care of a seriously ill family member—maximum of ten (10) calendar days per year.*
- _____ *Compensatory Time may be taken concurrently for any period of FMLA after eligible sick leave has been exhausted or for periods of FMLA that do not qualify for sick leave.*
- _____ *Leave No Pay must be taken concurrently for any period of FMLA after other leave has been exhausted. If the Leave No Pay will extend beyond 30 days, a Request for Extended Leave of Absence Without Pay Form must be completed.*

If leave is to be taken intermittently or if there will be a reduced work schedule, describe the schedule.

I certify that the information above is accurate. I understand that I will need to provide necessary medical documentation for any period of FMLA requested (on back of form) and that I will need to notify my department and/or Human Resources immediately if any of the information above should change.

EMPLOYEE _____ **DATE** _____

As the supervisor of the employee listed above, I am aware that the employee has applied for a Family Medical Leave Act leave. I understand that any leave taken must also be posted concurrently against the FMLA accrual. I will notify the Office of Human Resources immediately if I become aware of any changes to the information above.

SUPERVISOR _____ **DATE** _____

**CLEMSON UNIVERSITY
FAMILY MEDICAL LEAVE ACT (FMLA)
MEDICAL CERTIFICATION FORM
(To be completed by Health Care Provider)**

Please print in black ink.

ALL BOLDED AREAS MUST BE COMPLETED

EMPLOYEE'S NAME _____

PATIENT'S NAME (*If for care of a seriously ill family member*) _____

Is it medically necessary for the employee to be off work due to their personal illness or to care for a seriously ill family member:

Full-time basis? () Yes () No From _____ To _____

Intermittent basis? () Yes () No From _____ To _____

If FMLA to be taken intermittently please describe schedule: _____

Describe reason for FMLA; *employee's illness, to care of a seriously ill family member, describing the care the patient requires or for child birth.* _____

If FMLA is for illness of the employee: Is employee able to perform the essential job functions as described by the employee's position description? () Yes () No

If FMLA is for care of a seriously ill family member: Does the family member need assistance with their basic care? () Yes () No Related Information _____

Is inpatient hospitalization of the patient required? () Yes () No

From _____ **To** _____

NAME OF HEALTH CARE PROVIDER _____

SIGNATURE OF HEALTH CARE PROVIDER _____

NAME & TYPE OF PRACTICE _____

ADDRESS _____

TELEPHONE NUMBER _____ **DATE** _____

RETURN TO:
Dan Alder, Benefits Counselor
Clemson University – Human Resources
Box 345337 – Pearman Blvd
Clemson, SC 29634-5337
Phone (864) 656-4678 Fax (864) 656-4672

FOR OFFICE USE ONLY
The Office of Human Resources reserves the right to randomly verify the information provided on this document to include but not limited to medical condition, beginning and ending dates, supervisor's signature and physician's signature.