



REQUEST FOR FAMILY AND MEDICAL LEAVE

SAINT LOUIS UNIVERSITY EST. 1818

NAME \_\_\_\_\_ TIMEKEEPER \_\_\_\_\_
MAILING ADDRESS \_\_\_\_\_ BANNER ID # \_\_\_\_\_
DEPARTMENT \_\_\_\_\_ HOME PHONE \_\_\_\_\_
TITLE \_\_\_\_\_ WORK PHONE \_\_\_\_\_
DATE OF HIRE \_\_\_\_\_
SUPERVISOR \_\_\_\_\_ FACULTY [ ] STAFF [ ] HOUSE STAFF [ ]
POST DOCTORAL FELLOW [ ]

THE REASON YOU ARE REQUESTING A LEAVE IS (Check the appropriate box):

- [ ] Pregnancy, prenatal medical care or childbirth; to care for employee's child after birth; or placement for Adoption or foster care;
[ ] To care for the employee's spouse, son or daughter, or parent who has a serious health condition
[ ] Employee's own serious health condition that prohibits you from performing the function of your job
[ ] Military Leave for spouse, son, daughter, or parent on active duty

TYPE OF LEAVE REQUESTED: Check the appropriate box(s) & fill in start or expected delivery date and end date

- [ ] Consecutive Start date \_\_\_\_\_ End date \_\_\_\_\_ RTW date \_\_\_\_\_
[ ] Intermittent Start date \_\_\_\_\_ End date \_\_\_\_\_
[ ] Reduced Leave Schedule \_\_\_\_\_

When did you learn you needed to take this leave? \_\_\_\_\_

If your spouse works at SLU please list spouse's name: \_\_\_\_\_

Have you taken a leave under the FMLA policy during the past 12 months?

- [ ] No [ ] Yes From \_\_\_\_\_ to \_\_\_\_\_

Employee \_\_\_\_\_ Date \_\_\_\_\_

Manager \_\_\_\_\_ Date \_\_\_\_\_

Employee's manager should sign the request to acknowledge that employee has informed him or her of potential for FMLA use. Signature does not indicate FMLA approval. Fax the completed form to Human Resources at 314-977-1785 or email to fmla@slu.edu.