COMMUNITY COLLEGE
OF RHODE ISLAND

Request for FMLA Leave
Family and Medical Leave Act of 1993 &
RI Parental and Family Medical Leave Act

Community College of Rhode Island
400 East Avenue
Warwick RI 02888

FMLA # 188
Date of Application: Expires: 00-00-00

To request leave pursuant to the Family and Medical Leave Act & the Rhode Island Parental and Family Medical Leave Act, you must complete and return this form to the Office of Human Resources, 3rd Floor, 400 East Avenue, Warwick RI 02888. In order to be entitled to the leave, the employee must give at least thirty (30) days notice of the intended date upon which the requested leave is to commence and terminate, unless prevented by medical emergency from doing so. Employees are required to provide written certification from a physician caring for the person who is the reason for the FMLA leave request, which certification shall specify the probable duration of requested leave.

Employee Name: _____
(Print Name)

Department: _____ Supervisor/Dept Chair: _____

I am requesting this leave due to the serious health condition of:

☐ Self _____

☐ Spouse _____
(Print Name)

☐ Parent _____
(Print Name)

☐ Parent-in-law _____
(Print Name)

☐ Child _____
(Print Name)

Start date (first day of leave paid or unpaid) _____
First date of Unpaid Leave (if applicable) _____
Return Date (date of expected return to work) _____
Intermittent Schedule (paid or unpaid) _____ (if needed use back of form)

Reason for Requested Leave (Explain why leave is necessary):

_____

_____

All accrued balances must be used before going on leave without pay.

*M**edical certification is required** for medical/family leaves of absence. The health care provider's certification must include:

<> The date the health condition began;
<> The expected duration of the condition;
<> Appropriate medical facts necessary to verify leave requests;
<> An estimate of the amount of time required to be off work; and
<> If for a family member's serious health condition, a statement that the employee is needed to care for that family member.

Employee Signature: _____ Date: _____

I understand that if I do not return from my leave at the expiration of this leave, unless an extension has been approved in advance, my employment may be terminated

(Please forward completed application to The Office of Human Resources, Attention: Terri-Ann Milligan)

All Medical related documents are placed in Employee Confidential Medical Files

HR Office Use Only:

☐ Approved ☐ Recertification Requested ☐ Denied Date: _____

Office of Human Resources 06/04/2008