Request for Leave of Absence Form

*Request for Family or Medical Leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin. A completed Certification of Health Care Provider form must be submitted within **15 days** of a leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child, or parent. Return this form to Human Resources or Fax to (972) 985-3778.*

Name: _____ **CWID:** _____

Home Address: _____

Home Phone: _____

Job Title: _____ **Department:** _____

Supervisor: _____ **Work Phone:** _____

Campus: _____

Leave Requested for: ☐ Self
☐ Care for Family Member; Age: _____ Relationship: _____
☐ Qualifying Military Exigency; Relationship to service member: _____
☐ Illness/Injury of a Service Member; Relationship: _____

Anticipated Start Date of Leave: _____
Anticipated Return to Work Date: _____
Are you requesting leave on an intermittent basis? ☐ Yes ☐ No
Are you requesting leave on a reduced work schedule? ☐ Yes ☐ No
Reason for Leave: _____

Employee Agreement

I certify that the information provided is accurate to the best of my knowledge.

I have read the Collin College Leaves and Absences Board Policy - DEC (LOCAL) and am aware of my responsibilities that I will need to provide necessary documentation for any period of FMLA requested and that I will need to notify my supervisor and Human Resources immediately if any of the information above should change.

I have reviewed the U.S. Department of Labor - Fact Sheet #28: The Family and Medical Leave Act of 1993.

I understand that I will use all available paid leave. Leave will be paid only if employee has sufficient and appropriate accruals to cover part or all of the absence. I understand that if any of my leave is unpaid, I will be responsible for contacting the Human Resources Benefits Manager at (972) 548-6664 for information on payment of my share of the benefit premiums.

I hereby authorize Collin College to contact my health care provider to verify any information concerning my requested leave of absence.

I understand that failure to return from an approved Leave of Absence within the agreed upon timeframe may constitute a voluntary termination unless an extension has been agreed upon and approved in writing in advance by the College.

Employee Signature: _____ **Date:** _____

Collin College, Human Resources Department, Collin Higher Education Center,
3452 Spur 399, McKinney, TX 75069 Fax: 972-985-3778