

KANSAS STATE UNIVERSITY
FAMILY MEDICAL LEAVE ACT

(Revised 01/2007)

EMPLOYEE REQUEST FORM

Name _____ Employee ID
Number _____

Home Address _____

(City) (State) (Zip)

Home Telephone _____ Work Telephone _____

Name of Department/Unit _____

Request is for:

- _____ birth, adoption, or foster place
_____ serious health condition of employee
_____ care for my spouse, son, daughter or parent with a serious health condition

Note: If FMLA is requested for care of your spouse, son, daughter, or parent with a serious health condition, the following information must be provided:

Name of spouse, son, daughter, or parent and explanation of relationship: _____

Briefly explain reason for leave request: _____

Date FMLA leave is to begin: _____ Duration: _____

I certify that I understand, agree to, and meet the requirements and conditions set forth in KSU's Family and Medical Leave Act policy. I authorize Kansas State University to obtain any necessary information regarding my request for Family and Medical Leave.

Employee Signature Date

EMPLOYER RESPONSE TO EMPLOYEE REQUEST FOR FMLA LEAVE

_____ Approved
Leave begins _____ Leave ends _____
Number of workweeks used for FMLA _____
Leave used: _____ hours sick leave
_____ hours annual leave
_____ hours leave without pay

_____ Denied - Reason for denial:

Approving Authority Date