WENATCHEE VALLEY COLLEGE

**FAMILY AND MEDICAL LEAVE REQUEST FORM**

Eligible employees are entitled to up to 12 weeks (26 weeks for servicemember leave) of job-protected leave for certain family and medical reasons. If you wish to request family and medical leave under the [Family Medical Leave Act (FMLA) of 1993](http://www.dol.gov/WHD/fmla/index.htm), Washington’s Family Leave [RCW 49.78](http://apps.leg.wa.gov/RCW/default.aspx?cite=49.78), and WVC policy [500.200](http://commons.wvc.edu/hr/pp/500/Family%20Medical%20Leave.aspx) and procedure [1500.200](http://commons.wvc.edu/hr/pp/500/Family%20Medical%20Leave.aspx), submit this completed request form to the human resources office as early as practicable, preferably no fewer than 30 days in advance of the start of your leave. **If requesting intermittent or reduced schedule leave, you must attempt to work out a schedule with your supervisor which meets your needs without unduly disrupting your department’s operations.** WVC reserves the right to deny or postpone leave for failure to give appropriate notice.

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| **EMPLOYEE INFORMATION** | | | |
| First Name | Last Name | M. I. | Employee I.D. (SID or SSN) |
| Employing Department | | Job Title | |
| Name of Person with Medical Condition, if not the Employee | | Relationship to the Employee | |

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| **REASON FOR REQUESTING LEAVE**  1. I request leave for the following reason—please check the appropriate box.  Birth of my child; to care for my newborn child. Statement from healthcare provider required.  Placement of a child with me for adoption or foster care. [Statement form](https://www.wvc.edu/humanresources/media/documents/forms/FMLA-Statement-of-Adoption.docx) from the appropriate agency required.  To care for my family member with a serious health condition. Department of Labor certification form [WH-380-F](https://www.dol.gov/whd/forms/WH-380-F.pdf) required.  Name/Relationship of family member:  Please identify documentation on file (if any):  My own serious health condition which makes me unable to perform the functions of my position. Department of Labor certification form [WH-380-E](https://www.wvc.edu/humanresources/media/documents/forms/FMLA-Certification-for-Employee-WH-380-E%20w%20addendum.pdf) required.  A covered family member’s active duty or call to active duty in the Armed Forces. Department of Labor certification form [WH-384](https://www.dol.gov/whd/forms/WH-384.pdf) required.  Servicemember Family Leave (up to 26 weeks). Department of Labor certification form [WH-385](https://www.dol.gov/whd/forms/WH-385.pdf) required.  2. I request CONTINUOUS FMLA LEAVE starting (date):  and ending (date): .  3 I request INTERMITTENT FMLA LEAVE starting (date): . My anticipated schedule of absence is as follows (attach an additional sheet if needed): .  4. I request FMLA LEAVE in the form of a REDUCED WORK SCHEDULE from  hours/week to  hours/week starting (date):  and ending (date): .  5. Intermittent or reduced work schedule leave is medically necessary because: (attach an additional sheet if needed): . |

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| **EMPLOYEE STATEMENT OF UNDERSTANDING**  I am aware of and understand the following:   * I must submit the proper documentation to the human resources office within 15 days of submitting this request, or as soon as practicable. Failure to do so may result in my leave being delayed until I provide this documentation; * Before I return to work following a leave for my own serious illness, I may be required to present a fitness for duty certification to the human resources office; * My health benefits will continue during my leave and I am expected to continue to pay my share of health insurance premiums, if any; and, * If, under current college leave policies, I am eligible to lengthen this leave or request other leave benefits, I will submit the appropriate documents to the human resources office prior to the conclusion of my family and medical leave.   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Requesting Employee or Representative’s Signature Date Telephone |

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| ***For Use by Human Resources***  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Received by: Human Resources Signature Date |

Original: Medical File -