Lehigh University Faculty
Family and Medical Leave Request Form
For Leaves Related to the Birth of a Child or Placement of a Child in the Home

CONFIDENTIAL

Employee Name: ____

Lehigh ID or Social Security Number: ____

Department: ____

Supervisor or Department Chair: ____

I am requesting leave for the following reason(s):

☐ Pregnancy as a personal serious health condition (certification required)

☐ Birth of a child (Expected delivery date is: ______________________________)

☐ Adoption or placement of a child for foster care

Child's Name: ____

Scheduled date of adoption or placement: ______________________________

Primary Care Giver Designation:

☐ I am not the primary care-giver for this child.

☐ I am the primary care-giver for this child.

Primary Care Giver Certification

Primary care is defined as the day-to-day principal responsibility for the care of the child. To qualify as the primary care giver for a child, each of the following statements must be affirmed:

☐ I am the individual providing care to the child during the workday

☐ The child is not in the care of a professional child care provider during the workday

☐ The child is not in the care of another family member during the workday

☐ My spouse/partner is not providing care to the child during the workday

I certify that I will be the primary care giver for the child during the requested leave period and that all of the above statements are true.

Signature: ____ Date: ___________________________

Continued on next page.

Dates of Leave Requested:

- ☐ I request leave from ______________________ to ______________________.
- ☐ I request intermittent leave according to the following schedule:

  ____

  ____

- ☐ The total number of days of leave that I request is ______________________________.

EMPLOYEE STATEMENT:

I agree to return to work on _________________________. If circumstances change such that I will not be able to return to work on that date, I agree to inform the Provost Office and Human Resources and provide necessary documentation to support the change in return date.

I have read and understand the terms and provisions of the *Lehigh University Family Medical Leave Policies.*

Signature: ____ Date: __________________________

FOR PROVOST OFFICE USE ONLY:

Leave Dates Approved? ☐ Yes ☐ No Primary Care Designation Accepted? ☐ Yes ☐ No

Determination made by: ____

Title: ____ Date: _________________________

FOR HUMAN RESOURCES USE ONLY:

Certification Required? ☐ Yes ☐ No Certification Received? ☐ Yes ☐ No

Employee eligibility criteria:

Classification: ____

Length of Service: ____

Hours worked in last 12 months: ____

Family or medical leave taken in last 12 months: ____

Family or medical leave available: ____

Does leave requested qualify as family or medical leave? ☐ Yes ☐ No

Determination made by: ____

Title: ____ Date: _________________________