LEHIGH UNIVERSITY.
HUMAN RESOURCES OFFICE

Lehigh University Faculty and Staff
Family and Medical Leave Request Form

CONFIDENTIAL

TO BE SUBMITTED DIRECTLY TO THE HUMAN RESOURCES OFFICE

To be used by the Human Resources Office Only.

Employee Name: _____

Lehigh ID or Social Security Number: _____

Department: _____

Supervisor or Department Chair: _____

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

- ☐ Personal serious health condition, including pregnancy (certification required)
- ☐ Serious health condition of family member (certification required):
  - ☐ My Spouse/Partner (Spouse/Partner's Name: _____)
  - ☐ My Child (Child's Name: _____)
  - ☐ My Parent (Parent's Name: _____)
  - ☐ Service Member (Service Member's Name: _____)
    Service Member's Relationship to employee: _____
- ☐ Birth of a child (Expected delivery date is: _____)
  - ☐ I am the primary care-giver***** for this child. Please initial, if checked: _____.

    ***** "Primary care" is defined as the day-to-day principal responsibility for the care of a child, and is not intended to include parents whose child is in the full-time care of a spouse/domestic partner or a professional care provider.
  - ☐ I am not the primary care-giver for this child.
- ☐ Adoption or placement of a child for foster care

  Child's Name: _____

  Scheduled date of adoption or placement: _____
  - ☐ I am the primary care-giver for this child.
  - ☐ I am not the primary care-giver for this child.
- ☐ Qualifying exigency due to active military duty or pending call or order to active duty of family member

  Name of Service Member: _____

  Relationship to Employee: _____

Continued next page.

Dates of Leave Requested:

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

  _____

  _____

- ☐ I request a reduced schedule 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 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 HUMAN RESOURCES USE ONLY:

Employee: _____

Requested Dates of Leave: _____

Request Received: _____

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: _____