



**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: \_\_\_\_\_

**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: \_\_\_\_\_

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**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: \_\_\_\_\_