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: _____