

AFC Unit _____

A72.200

REQUEST FOR FAMILY AND MEDICAL LEAVE

To: _____
AFC Supervisor

Date: _____

From: _____
Employee Name

AASIS # _____

Please place me on Family and Medical Leave for _____ (days, weeks, months) to begin on _____ and end on _____.

I understand that Family and Medical Leave is without pay. The AFC requires that I use all paid leave before going on unpaid leave; except, employees who take maternity leave have the option to reserve annual and sick leave balances. Paid leave is charged against the Family and Medical Leave Act entitlement.

During a period of Family and Medical Leave the AFC will continue paying the employer's matching portion of my Group Health Insurance Premium. I am responsible for paying the employee's portion of the premium each pay period. If I do not, my insurance may be cancelled after 30 days.

Please check the appropriate box below:

This period of Family and Medical Leave will be without pay.

Accrued annual or sick leave or approved catastrophic leave will be substituted for unpaid leave.

Approved

Disapproved

Employee's Signature

Supervisor's Signature

Employee's Social Security Number

Human Resources Administrator