Oglethorpe University
Leave of Absence Request Form

Submit this form to your supervisor/department manager. Your department will notify you of your leave of absence status. (If employee is unavailable, the department manager completes this section). This form must be sent to Human Resources for approval.

FMLA Leave of Absence Eligibility: You must be employed for at least one year and have worked at least 1250 hours in the 12 months preceding the leave request.
FMLA Provisions: You may be eligible for up to 12 weeks of job protected leave, without pay, within a 12 month period, with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. If you are the spouse, son, daughter, parent, or next of kin of a covered service member who has a serious injury or illness, a combined total of 26 weeks of leave (including traditional FMLA leave) in a 12-month period is allowed.
Reinstatement: If you return to work within 12 weeks (or 26 weeks, if applicable), you will be returned to the same or equivalent position with equivalent pay, benefits (if enrolled) and other employment terms.

Employee Name: ______________________________

Job Title: ______________________________ Phone Ext. ______________

Department: ______________________________

Type of leave of absence requested:

☐ **Family and Medical Leave of Absence** – 30-day notice period where reasonably foreseeable

    ☐ Continuous Leave

    ☐ Intermittent Leave

☐ **Medical Leave of Absence (may require medical certification)**

☐ **Military Leave of Absence** – Attach copy of military orders

Reason for FMLA Leave (if applicable):

☐ Birth of a child or the placement of a child with you for adoption or foster care (within 12 months of the birth or placement of a child).

☐ A serious health condition affecting your ☐ parent ☐ spouse ☐ child for which you are needed to provide care.

☐ A serious health condition, which prevents you, the employee, from performing the essential functions of your job.

☐ A serious injury or illness affecting your ☐ spouse ☐ child ☐ next of kin who is a covered service member and for which you are needed to provide care.

Expected Dates of Absence: From _______/_______/_______ To _______/_______/_______

Intermittent schedule (If Applicable): ______________________________

ADDRESS WHILE ON LEAVE: ______________________________

Telephone Number While on Leave ______________________________

Employee Signature______________________ Date______________________