



Stonehill College Employee Request for Leave of Absence

Name: _____ Date _____

Dept. _____ Position _____

Status: ___ Full-Time ___ Part-Time ___ Hrs Worked ___ Calendar Yr. ___ Academic Yr.

I request a leave of absence for the period and reason indicated:

Anticipated Start Date: _____ Anticipated End Date: _____

The Family and Medical Leave Act (FMLA) provides up to twelve (12) weeks of unpaid, job – protected leave to eligible employees for certain family and medical reasons. Employees are eligible for FMLA if you have at least 12 months of service and if you have worked at least 1,250 hours during the 12 months prior to the requested leave. See Family and Medical Leave Act Policy Number F9.28 for additional information.

In some instances, an entire authorized leave of absence or a portion of an authorized leave of absence may be paid. Determination of the paid or unpaid status of leave is dependent upon various factors and policies.

Type of Leave:

Family Medical Leave (FMLA)

Medical:

___ Care of Self/Serious Medical Condition
*(requires medical documentation**)*
___ Care of Dependent Child
___ Care of Spouse or Dependent Parent

Parental:

___ Birth/care of child
___ Adoption
___ Foster Care
___ Placement

Other:

___ Military Duty ___ Personal Leave* ___ Medical

For all leaves of absence the Human Resources Department will notify your supervisor that a leave of absence has been requested. The nature of the leave will remain confidential.

Contact the Human Resources Department at least five (5) days prior to your anticipated return to work date.

*Personal leaves of absence may require prior approval by your supervisor. Human Resources can, at your request, work with your supervisor to obtain approval, if appropriate.

**Required medical documentation will be maintained only in confidential medical files, secured in the Human Resources Department

Employee Signature _____ Date _____

Human Resources Signature _____ Date _____