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Request for
Family and Medical Leave Act (FMLA) Leave

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Part I : TO BE COMPLETED BY EMPLOYEE

Type of FMLA Request (check one): ☐ Initial Request ☐ Recertification ☐ New Request (Previous FMLA period expired)

1. Name:

2. Social Security Number:	**3.** Work Location:
4. Position Title:	**5.** Date of Hire:

6. Eligibility

- Counting any periods of time that you worked for CSC (whether they were consecutive or not), have you worked for CSC for a total of 12 months or more? Yes☐ No☐
- During the past 12 months, have you worked at least 1,250 hours? Yes☐ No☐
- Have you previously been granted FMLA leave? Yes☐ No☐

  If yes: Date of leave From_____ To_____

  Purpose of leave: _____
- Have you taken any intermittent leave? Yes☐ No☐
- Have you taken time off from scheduled hours? Yes☐ No☐

  If "yes", provide details:_____ _____

7. Reason for requested leave *(check all that apply):*

☐ **a.** Birth of a child (attach completed Form WH 380 E or WH 380 F)
☐ **b.** Placement of a child for adoption or foster care (attach court documents)
☐ **c.** Care for an immediate family member who has a serious health condition (attach completed Form WH 380 F)
☐ **d.** My own serious health condition (attach completed Form WH 380 E)
☐ **e.** Qualifying Exigency for Military Family Leave (attach completed Form WH 384)
☐ **f.** Military Caregiver Leave for Military Family Leave (attach completed Form WH 385 V)

If you selected "c", please state the name, relationship and address of the family member:

Name: Relationship: Address:

8. Date on which you wish to commence leave:	**9.** Date of anticipated return to work:

10. Are you requesting leave on an intermittent or reduced leave schedule? Yes ☐ No ■

11. If you answered "Yes" to #10, please specify a schedule of when you will be available for work. **NOTE:** Please be advised that the request for a modified work schedule must be reviewed and approved by the employee's Supervisor and/or Department Head as well as the Department of Human Resources.

Schedule (Please attach a separate sheet if necessary):

Employees seeking leave must complete the appropriate medical certificate form and return it within 30 days, or as soon as practicable. I understand that my leave may be delayed until I provide a completed medical certification form. I understand that CSC may require further medical certification during the course of the leave, as deemed appropriate, for treatment that is scheduled during work hours for serious medical conditions and that I will provide accurate and timely information related to a request for continuation of modification(s) to and return from leave.

Employees seeking to return to work after a leave because of their own serious illness (Reason 7d) also must provide certification of their fitness to return to work. I understand that I may not be permitted to resume my position with CSC, until I provide certification of my fitness to return to work.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums. I understand that if I do not pay my health insurance premiums my health insurance will be discontinued. I also agree that if I fail to return to work at the end of the leave period, I will reimburse CSC for the payments made by CSC for my health benefits during my leave, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period I will reimburse CSC for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of serious health conditions, I will provide medical certification from the date that my leave expired, or that I am needed to care for a covered relation because he/she has a serious health condition on the date that my leave expired.

Signature of Employee:	Date:

Part II: TO BE COMPLETED BY EMPLOYEE'S DEPARTMENT

The FMLA leave request has been reviewed with employee. The employee will be restored to the same or equivalent position upon the conclusion of the leave.

Supervisor's Remarks:

Signature of Supervisor: Date:

Department Head's Remarks:

Signature of Department Head: Date:

Part II: TO BE COMPLETED BY HR DEPARTMENT

Has the employee been employed with CSC for a total of 12 months? Yes ☐ No ☐
During the past 12 months, has the employee worked at least 1,250 hours? Yes ☐ No ☐

Has this employee previously received medical or family leave? Yes ☐ No ☐

If yes: Date of leave From_____ To_____

Has this employee taken any intermittent leave? Yes ☐ No ☐

If yes how much _____

Has this employee taken time off from scheduled hours? Yes ☐ No ☐

If yes how much _____

Total time entitled still due:_____

FMLA Leave request Approved_____ Denied_____

Reason_____

Signature of Human Resources' Designee: Date:

Copies of the request for leave, certification forms and any modifications to them during the period of leave shall be forwarded to CSC's Department of Human Resources to become part of the employee's official Family and Medical Leave file.

Notification for
Family and Medical Leave Act (FMLA)

For Human Resources Use Only

To (Employee's Name):	Date:

Re: ☐ Initial FMLA Request ☐ Recertification ☐ New FMLA Request (Previous FMLA period expired)

Your request for ☐ continuous or ☐ intermittent leave under the FMLA and supporting documentation that you have provided were received and reviewed by the Department of Human Resources. Based on the review of information, the following have been concluded:

☐ Your FMLA Leave request is approved.

☐ You are required to exhaust all of your available accrued leave during your FMLA absence. This means that your leave usage will be counted against your FMLA leave entitlement.

☐ Contact _____ at _____ to make arrangements to continue to make your share of the premium payments to maintain health benefits while you are on unpaid leave. You have a minimum 30-day (or, indicated longer period, if applicable) grace period in which to make premium payments. If payment is not made in a timely manner, your group health benefits may be cancelled.

☐ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not received in a timely manner, your return to work may be delayed until certification is provided.

☐ Your FMLA Leave request is not approved.

☐ The FMLA does not apply to your leave request.

☐ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

☐ Additional information is needed to determine if your FMLA leave request can be approved. Such information consist of _____

☐ The certification you have provided is not complete and insufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied. Information needed to make the certification complete and sufficient:

☐ Your recertification for continued leave under FMLA ☐ has ☐ has not been approved.

Additional Comments:

Signature of Human Resources' Designee: Date:

Family and Medical Leave Act (FMLA)
Return to Work Form

*****This form must be completed for any serious health condition of the employee prior to their return to work*

Part I: EMPLOYEE INFORMATION (to be completed by Employee)			
Employee Name:			
Work Location:		Position Title:	
Home Address:		Home Phone:	

Part II: MEDICAL RETURN TO WORK CERTIFICATION (to be completed by the Health Care Provider)			
Name of Health Care Provider:			
Name of Health Care Practice:			
Address:			
Phone:		Date of Examination:	
Name of Employee:		Name of Patient:	
Date employee is released to return to work:			
Is the employee able to perform the essential functions of his/her position as of the return to work date?		☐ YES ☐ NO	
Additional Comments:			
CERTIFICATION: I affirm that the information provided above is true and accurate to the best of my knowledge.			
Signature-Health Care Provider:		Date:	

Part III: CERTIFICATION OF RETURN TO WORK (to be completed by HR)	
Date Leave of Absence (or reduced/intermittent schedule) Began:	
☐ Date Employee Returned to Work at Regularly Scheduled Hours: Note: If an employee is returning to work on a reduced or intermittent work schedule, do not complete this form. Instead, complete a new "Medical Leave – Leave Request Form" and check the "Supplement to Previous Request" box at the top right corner.	
☐ Employee IS NOT returning to work. Separation Date is:	

Signature of Human Resources' Designee:	Date: