



Family and Medical Leave (FMLA) Application

A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child or parent must be accompanied by a verifying medical certification from a physician.

Name _____ Department _____

Home Address _____

Start Date of Anticipated Leave _____

Expected Date of Return to Work _____

Reason for Leave (Please explain): _____

I hereby authorize Mott Community College to contact my health care provider to verify the reason for my requested leave or for any other information concerning my request for family and medical leave.

I understand that failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by Mott Community College.

If I do not return to work after an unpaid FMLA leave, or return for less than 30 calendar days after an unpaid FMLA leave, I understand that I am responsible for reimbursing the College for all the fringe benefit expenses the College incurred while I was on FMLA leave. In this event, I authorize the College to withhold from my last paycheck the amount of any fringe benefit expenses I owe.

Employee Signature _____ Date _____

Supervisor _____ Date _____

Human Resources Representative _____ Date _____

Chief Human Resources Officer _____ Date _____