



VILLANOVA UNIVERSITY

FAMILY AND MEDICAL LEAVE REQUEST (To be completed by Employee)

Name: _____ Title: _____

Department: _____ Today's Date: _____

Telephone Number: _____

I am requesting Family and Medical Leave due to:

the birth of my child or the placement of my adopted child or foster child in my home

my own serious health condition (specify) _____

a serious condition affecting my spouse parent child, for whom I need to provide care

Leave to begin: _____ Anticipated End Date: _____

Leave will be:

Full Time Intermittent (partial weeks) Reduced work schedule (partial days)

Number of FMLA Days I have taken in the last 12 months _____

To be eligible for leave under the Family and Medical Leave Act, you must have worked for Villanova University for at least one year and at least 1250 hours in the last 12 months. Please refer to the FMLA Policy, on the Human Resources website under Family Benefits, for more information.

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

Signature: _____ Date: _____

Received in Human Resources by: _____ Date: _____