FAIRLEIGH DICKINSON UNIVERSITY

APPLICATION FOR FAMILY MEDICAL LEAVE AND STATE FAMILY LEAVE

THIS FORM MUST BE RETURNED DIRECTLY TO THE BENEFITS DEPARTMENT TO ELIMATE DELAY IN PAY BY THE UNIVERSITY PAYROLL DEPARTMENT. PLEASE RETURN THE COMPLETED FORM TO THE ADDRESS AS FOLLOWS:
FDU, ATTN; S. MILLER, 1000 RIVER ROAD, H-DH3-05, TEANECK, NJ 07666
OR VIA FAX 201-692-2709

Name: _____ Location: _____

Address: _____

_____

Start Date of Anticipated Leave: _____

Expected Date of Return to Work: _____

Reason for Leave: _____

_____

_____

_____

NOTE: When a request for leave is based on an employee's serious health condition, or the serious health condition of the employee's family member or a "Covered Servicemember," or for a "qualifying exigency," the University may require the employee to submit a Certification of Health Care Provider, Certification of Serious Injury or Illness for Covered Serivcemember, or Certification of Qualifying Exigency. You will be notified if the University requires a Certification.

For employees receiving 3rd party sick pay - temporary disability or workers' compensation benefits, or Family Leave Insurance ONLY:*

I hereby elect to supplement my benefit payments with the following during the period of my FMLA-qualifying leave (check all that apply):

____ My accrued, unused sick and/or personal time

____ My accrued, unused vacation time

For employees on FMLA/State FLA Only (NOT Receiving 3rd Party Sick Pay).

Unused sick time will automatically be deducted during your leave. Should you exhaust your sick bank and authorize payroll to deduct from you Accrued, unused Vacation time, please indicate below.

____ I authorize Payroll to use my accrued, unused vacation time

** Employees taking unpaid FMLA leave should consult their Employee Handbook for information regarding substitution of paid leave.*

Employee Signature: _____ **Date:** _____