



COMMUNITY COLLEGE  
OF RHODE ISLAND

Request for FMLA Leave  
**Family and Medical Leave Act of 1993 &  
RI Parental and Family Medical Leave Act**

**Community College of Rhode Island**  
400 East Avenue  
Warwick RI 02888

Date of Application:

FMLA # 188  
Expires: 00-00-00

To request leave pursuant to the Family and Medical Leave Act & the Rhode Island Parental and Family Medical Leave Act, you must complete and return this form to the Office of Human Resources, 3<sup>rd</sup> Floor, 400 East Avenue, Warwick RI 02888. In order to be entitled to the leave, the employee must give at least thirty (30) days notice of the intended date upon which the requested leave is to commence and terminate, unless prevented by medical emergency from doing so. Employees are required to provide written certification from a physician caring for the person who is the reason for the FMLA leave request, which certification shall specify the probable duration of requested leave.

Employee Name: \_\_\_\_\_  
(Print Name)

Department: \_\_\_\_\_ Supervisor/Dept Chair: \_\_\_\_\_

**I am requesting this leave due to the serious health condition of:**

- Self \_\_\_\_\_
- Spouse \_\_\_\_\_  
(Print Name)
- Parent \_\_\_\_\_  
(Print Name)
- Parent-in-law \_\_\_\_\_  
(Print Name)
- Child \_\_\_\_\_  
(Print Name)

Start date (first day of leave paid or unpaid) \_\_\_\_\_

First date of Unpaid Leave (if applicable) \_\_\_\_\_

Return Date (date of expected return to work) \_\_\_\_\_

Intermittent Schedule (paid or unpaid) \_\_\_\_\_ (if needed use back of form)

Absence is to be (check each that applies)

- Fully Paid (please explain) \_\_\_\_\_
- Partially Paid (please explain) \_\_\_\_\_
- Unpaid

Should vacation benefits be used?  No  Yes  Not Applicable

If yes, number of hours to be applied: \_\_\_\_\_ or  All

Reason for Requested Leave (Explain why leave is necessary):

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**\*Medical certification is required** for medical/family leaves of absence. The health care provider's certification must include:

- ◇ The date the health condition began;
- ◇ The expected duration of the condition;
- ◇ Appropriate medical facts necessary to verify leave requests;
- ◇ An estimate of the amount of time required to be off work; and
- ◇ If for a family member's serious health condition, a statement that the employee is needed to care for that family member.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I understand that if I do not return from my leave at the expiration of this leave, unless an extension has been approved in advance, my employment may be terminated

(Please forward completed application to The Office of Human Resources, Attention: Terri-Ann Milligan)

All Medical related documents are placed in Employee Confidential Medical Files

**HR Office Use Only:**

Approved  Recertification Requested  Denied Date: \_\_\_\_\_

Office of Human Resources

06/04/2008