

WESTERN MICHIGAN UNIVERSITY

FAMILY & MEDICAL LEAVE REQUEST

New Request Extension Request

Employee Name _____

Employee ID _____

Street Address _____

Department _____

City, State, Zip _____

Supervisor _____

Home Phone _____

Date of Hire _____

Work Phone _____

Date Last Worked _____

Reason for Family/Medical Leave:

For the birth of my son or daughter and the care of such newborn child.

Does your spouse work at WMU? No Yes-Name of Spouse _____

For the placement of a child with me for adoption or foster care.

Does your spouse work at WMU? No Yes-Name of Spouse _____

For my serious health condition.

To care for my spouse, child, or parent who has a serious health condition.

Name of Spouse _____

Name of Parent _____

Name of Child _____ Age of Child _____

Because of a qualifying exigency arising out of the fact that my spouse, child, or parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.

Name of Spouse _____

Name of Parent _____

Name of Child _____

Because I am the spouse, child, parent, or next of kin of a covered service member with a serious injury or illness. FMLA leave for a serious health condition of the employee or a family member, or for a covered service member with a serious injury or illness, requires medical certification from a health care provider within 15 days of leave application.

Medical certification is due to Human Resources (fax 269-387-3441) by _____.

