Southern University System

SUBR _____ SUS _____ SULC _____ SUNO _____ SUSLA _____ SUAREC _____

Application for Family or Medical Leave

Name: _____ Date: _____

Current Address: _____

Start Date of Anticipated Leave: _____

Expected Date of Return to Work: _____

NOTE: 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 completed Certification of Health Care Provider form.

ONLY the Office of Human Resources can verify or confirm the validity of a request for medical leave. All department heads, supervisors and anyone privy to an employee's health information must maintain strict confidentiality of the health information.

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 **Southern University.**

I further understand that falsification of medical documentation will result in termination of employment.

EMPLOYEE SIGNATURE: _____ DATE: _____

APPROVED BY:

_____ _____

Supervisor/ Department Head Date

_____ _____

Director of Human Resources Date

Revised 04/11

RESET FORM ***PRINT FORM***