SOUTHERN STATE COMMUNITY COLLEGE

Family and Medical Leave (FMLA) Application

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 verifying medical certification from a physician.

Name _____ Department _____

Home Address_____

Start Date of Anticipated Leave _____

Expected Date of Return to Work _____

Reason for Leave (Please explain): _____
_____

I hereby authorize Southern State Community College to contact my health care provider to verify the reason for my requested leave or for any other information concerning my request for family and medical leave.

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 State Community College.

If I do not return to work after an unpaid FMLA leave, or return for less than 30 calendar days after an unpaid FMLA leave, I understand that I am responsible for reimbursing the College for all the fringe benefit expenses the College incurred while I was on FMLA leave. In this event, I authorize the College to withhold from my last paycheck the amount of any fringe benefit expenses I owe.

Employee Signature: _____ Date: _____

FMLA POLICY ACKNOWLEDGEMENT:
I have received a copy of the College's FMLA Policy. I have read and understand the conditions set forth within the policy. If if have any questions, I will contact Crystal Howland at 937.393.3431 ext. 2560 or chowland1@sscc.edu.

Employee Signature: _____ Date: _____

_____ _____
Supervisor Date

_____ _____
Human Resources Representative Date