DIVISION OF AGRICULTURE
RESEARCH & EXTENSION
University of Arkansas System

July 1, 2020

REQUEST FOR CONSIDERATION UNDER THE FAMILY AND MEDICAL LEAVE ACT

To: **Human Resources Office**

Date: .....

University of Arkansas System Division of Agriculture (UADA)
2301 South University Avenue
Little Rock, AR 72204

From:

Employee Name	**Home Phone**
Home Street Address	**City/Zip**
Work Location/County/Dept.	**Work Phone**
Supervisor Name	**Supervisor Work Phone**

I am requesting FMLA for: (check one)
☐ A block of time (dates determined by physician on WH380E/WH380F Physician Certification)
☐ Intermittent (dates determined by physician on WH380E/WH380F Physician Certification)

I am requesting FMLA on the following estimated beginning date:

I am requesting FMLA for:
(check one)

☐ Birth of a child, or placement of a child with you for adoption or foster care
☐ Your own serious health condition
☐ Care for a spouse ☐, child ☐, or parent ☐ due to his/her serious health condition
☐ A qualifying exigency for a spouse☐, child ☐, or parent ☐ on active military duty
☐ You are the spouse ☐ child, ☐ parent ☐, or next of kin ☐ of a covered service member with a serious health condition

Note: Eligible employees may request FMLA leave consecutively (a single block of time) or intermittently (leave taken at separate blocks of time due to a single qualifying event). Dates of any approved leave will be determined by information provided on the WH380E/WH380F Physician Certification. The Human Resources Office may contact your Health Care Provider for clarification/authenticity of your medical certification if required.

For questions regarding FMLA, contact Human Resources at 501-671-2219.

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Employee Signature	**Employee I.D. Number**

HR Office Use Only:

This request was received in Human Resources on the date listed below.

_____	_____
Human Resources Representative	**Date**