WELLESLEY COLLEGE
REQUEST FOR FAMILY OR MEDICAL LEAVE

Employee's Name: ________________________________

Reason for Leave:                                   Check One:

1. Employee’s own serious health condition          _____

2. Serious health condition of your:
   Child __________________________ (Name)          _____
   Spouse __________________________ (Name)          _____
   Parent __________________________ (Name)          _____

3. Birth of child                                  _____

4. Adopting or placement of a child for foster care _____

Anticipated Date of Leave: ________________________
Anticipated Date of Return: ________________________ (Employee to complete)

Certification:
If your need for leave is due to either your serious health condition or the need to care for a
seriously ill child, spouse, or parent, you must provide medical certification by a health care
provider before or at the commencement of your leave stating:

1. the date on which the condition commenced;
2. the probably duration; and
3. medical facts surrounding the condition

The form for medical certification will be available from Human Resources. For your own medical
leave the certification must also include a statement by your health care provider that you are or
will be unable to perform your job functions.

For family medical leave, the medical certification should include an estimate of the amount of
time you will be needed to care for your child, spouse, or parent.

The Company may require periodic recertification during the leave, and may request a second
medical opinion at Company expense. If the first and second opinions differ, the Company may
require the opinion of a third health care provider (approved by both the Company and you)
whose opinion will be binding.

If the need for leave does not allow for time to present prior medical certification, certification
should be provided as soon as possible after the commencement of the leave.
Employee Acknowledgments:

1. My qualified health care provider currently anticipates (and has documented in writing) that I will be physically/mentally able to return to work on the first day following the date my FMLA leave ends.

2. I currently intend to return to work on the first day following the date my FMLA leave ends, if my qualified health care provider gives me medical clearance.

3. If I accept employment elsewhere or become self-employed during my FMLA leave, I understand that my employment may be terminated automatically.

4. CHECK “A”, “B”, OR “C” below

   (A) During my FMLA leave of absence, I want my group health insurance coverage to remain in effect, and I understand that in order for my group health insurance coverage to remain in effect, I agree I will pay the current amount of my contribution (if any) to the insurance premium in advance or weekly, and I also hereby authorize the Company to deduct the current amount of my contribution to the insurance premium from any paychecks which I receive from the Company, if necessary. **If you select choice “A” check here:**

   (B) I do not want my group health insurance coverage to remain in effect during my FMLA leave. **If you select choice “B”, check here:**

   (C) I do not have group health insurance coverage through the company. **If you select choice “C”, check here:**

5. I understand I am eligible to receive holiday pay or accrue vacation, sick, or personal time during my FMLA leave.

6. I understand my accrued, but unused vacation, sick or personal time (if any) may be applied to my FMLA leave at its commencement, unless my leave runs concurrently with a worker’s compensation leave.

7. If my absence is the result of a workplace injury which is covered by worker’s compensation, the fact that my FMLA leave will run concurrently with my worker’s compensation leave will not negatively impact or affect my rights under worker’s compensation laws.

________________________________________  __________________________
Employee Signature                              Date

________________________________________  __________________________
Supervisor’s Signature                          Date

Forms to be returned to: Wellesley College
106 Central Street
Wellesley, MA  02481

**Faculty:** return form to the attention of Ruth Frommer, Office of the Provost  
**Staff (admin. & union):** return form to the attention of JoAnne O’Beirne, Human Resources