UNIVERSITY OF ARKANSAS AT PINE BLUFF
REQUEST FOR FMLA LEAVE

Date:____ Department:___________________________________

I request to be placed on leave to begin on________________________and ending________________________both dates inclusive.

I request that this leave be considered leave under the Family Medical Leave Act of 1993, and be counted toward my annual entitlement of twelve (12) weeks. I understand that the leave will run concurrently with any accrued sick and annual leave. Any remaining leave taken will be unpaid leave.

The reason(s) for my FMLA request is (are):

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I have read and understand the Family Medical Leave information. Also, I have received a copy of the policy and my rights and responsibilities under the Family Medical Leave Act. I further understand that it is my responsibility to personally pay the employee portion of the insurance premium and that If I do not, my insurance will be canceled after 30 days.

____ ________________________

Employee Signature Date