



Application for Family or Medical Leave

Name: _____ School/Department: _____

Current Address: _____

Start Date of Anticipated Leave: _____

Expected Date of Return to Work: _____

Reason for Leave (explain): _____

NOTE:

An employee requesting leave for the employee's serious health condition or the serious health condition of the employee's spouse, child or parent must submit a verifying medical certification from a physician within 15 days of application for leave.

I hereby authorize a health care provider representing Mercer University to contact my physician to verify the reason for my requested family and medical leave.

I understand that a 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 Mercer University.

Signature: _____ Date: _____

APPROVED BY:

Supervisor

Associate Vice President, Human Resources