Community College of Philadelphia

Office of Human Resources
215-751-8038 or 8208
Fax: 215-972-6307

Request for Family & Medical Leave
TO BE COMPLETED BY EMPLOYEE

1. Name of Employee_____
   First Name Middle Initial Last Name
2. Employee's Position _____ Department _____
   ☐ Full-time ☐ Part-time
3. Reason for requested leave
   - ☐ a. Birth of a newborn son or daughter of the employee and care of a newborn son or daughter of the employee. (*Please notify Benefits Department within 30 days to add baby to health and dental insurance*.)
   - ☐ b. Placement of a son or daughter with the employee for adoption or foster care.
   - ☐ c. Care for spouse, child or parent with a serious health condition.
   - ☐ d. Employee's own serious health condition which makes employee unable to perform the functions of his/her position.
   - ☐ e. To care for a covered family member who has incurred an injury or illness in the line of duty while on active duty in the Armed Forces provided that such injury or illness may render the family member medically unfit to perform duties of the member's office, grade, rank or rating.
4. If "c" or "e", please check one: ☐ Spouse ☐ Child ☐ Parent ☐ Next of Kin
5. If "c" or "e", state name and address of relation.
   _____
   _____
   _____
6. Date on which you wish to commence leave. _____
7. Date of anticipated return to work. _____
8. Are you requesting leave on an intermittent or reduced leave schedule? ☐ Yes ☐ No
9. If "yes", please give schedule of when you anticipate you will be unavailable for work.
   (i.e., dates of scheduled medical appointments)
   _____
   _____

Employees seeking leave because of reason "3(c)" "3(d)" or "3(e)" above, must complete a Medical Certification Form and return it within 15 days, or as soon as possible. I understand that I may not be permitted to resume my position with CCP until I provide a completed Health Care Provider Release to Return To Work form.
If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired or that I am needed to care for a covered relation because he/she has a serious health condition on the date that my leave expired.

Employee_____ Date_____
Signature *Please Print*

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Supervisor or Department Chair:
By signing this form, you acknowledge that you are aware that your employee has requested family & medical leave.

Employee Supervisor_____ Date_____
Signature *Please Print*

Vice President/Applicable Dean_____ Date_____
Signature *Please Print*

RETURN FORM TO OFFICE OF HUMAN RESOURCES