Mount Vernon Nazarene University
Application for Family or Medical Leave

Name:

Department:

Current Home Address:

NOTE: A leave request based on an employee's serious health condition or the serious health condition of an employees spouse, child or parent must be supplemented by a verifying medical certification from a physician. **The employee should provide the medical certification within 15 days after the request for FMLA leave.**

Start Date of Anticipated Leave:

Expected Date of Return to Work:

Reason for Leave (explain):

I hereby authorize (the health care provider designated by Employer) to contact my physician to verify the reason for my requested leave or for any other information concerning 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 the Human Resources Department.

Employee Signature:

Date:

APPROVAL:

Supervisor Signature:

Date:

Human Resources Director Signature:

Date: