

**Employee Instructions:** It is your responsibility to ensure this form is submitted 30 days in advance of your expected leave date. Complete your portion of this form, then meet with your direct supervisor for them to complete their portion. The required forms to support this request must be hand-delivered to the HR Office at 83 Langdon Street or faxed to HR Benefits at (603) 535-2655 upon completion of this form. Additional information can be located at [www.campus.plymouth.edu/human-resources](http://www.campus.plymouth.edu/human-resources).

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

9-Digit USNH ID: \_\_\_\_\_ Department: \_\_\_\_\_ Job Title: \_\_\_\_\_

Leave Reason – Please check all that apply	Instructions
<input type="checkbox"/> Medical – for your own medical condition <i>Is medical leave due to the birth of your child?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	File your claim at <a href="http://metlife.com/mybenefits">metlife.com/mybenefits</a> or by calling (888) 608-6665
<input type="checkbox"/> Medical - due to your work-related injury (Workers' Compensation)	Confirm that your WC medical report is on file with HR
<input type="checkbox"/> Care for an immediate family member with a serious health condition <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> parent	File your claim at <a href="http://metlife.com/mybenefits">metlife.com/mybenefits</a> or by calling (888) 608-6665
<input type="checkbox"/> Parental (Bonding) Leave – care for a child within the first 12 months of life or first 12 months of foster care/adoption placement	File your claim at <a href="http://metlife.com/mybenefits">metlife.com/mybenefits</a> or by calling (888) 608-6665
<input type="checkbox"/> Personal Leave (if none of the above apply)	Contact your supervisor
<input type="checkbox"/> Military Leave - for self or family member	Contact HR Benefits

Expected Dates of Leave: **Expected dates must be entered and it is understood that these dates could change.**

I request a consecutive leave beginning \_\_\_\_/\_\_\_\_/\_\_\_\_ and I expect to return \_\_\_\_/\_\_\_\_/\_\_\_\_

I request an intermittent leave beginning \_\_\_\_/\_\_\_\_/\_\_\_\_ and I expect it to end \_\_\_\_/\_\_\_\_/\_\_\_\_

**Employee Acknowledgement:** I understand that this form is a request for a leave of absence from Plymouth State University and not an approval. I will receive notice from MetLife regarding the approval of the Family and Medical Leave Act (FMLA), including any rights I may have under FMLA. I understand that if I do not provide the required documentation to support this request in a timely manner, it may result in loss of some or all of my leave benefits.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Supervisor Instructions:** Complete the bottom part of this form entirely. Once this form is completed, with appropriate signatures, you need to provide a copy to the employee & hand-deliver or fax to HR Benefits at (603) 535-2655.

**Supervisor Acknowledgement:** By signing below you are acknowledging receipt of this request. MetLife will notify the employee of approval and provide information of any benefits available under the federal Family and Medical Leave Act (FMLA) if applicable.

Supervisor/Chair Name: \_\_\_\_\_

Supervisor/Chair Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_