



University of Alaska

Request for Family and Medical Leave

Complete this form if you are requesting leave for yourself or to care for a family member with a serious health condition.

Employee's Name: _____ Phone: _____

Employee ID: _____

Supervisor's Name: _____ Phone: _____

Leave start date: _____ Leave end date: _____

Type of Leave:

- Continuous
- On an intermittent basis as described below:

- On a reduced work schedule as described below:

Reason for Leave:

- The birth, adoption, or foster care placement of a son or daughter, or to care for the child within the first 12-month period following the birth, adoption, or placement.
- A serious health condition affecting an immediate family member (*please complete a Physician/Practitioner Certification of Health Care form*):

Name of family member _____

- A serious health condition that makes me unable to perform the essential functions of my job. (*please complete a Physician/Practitioner Certification of Health Care form*).

- Other (*please describe*): _____

Employee Signature _____ Date _____