

**REQUEST FOR FAMILY AND MEDICAL LEAVE:  
NOTICE OF ACKNOWLEDGEMENT OF FAMILY MEDICAL GUIDELINES**

Employee's Name: \_\_\_\_\_

Job Title: \_\_\_\_\_ Department: \_\_\_\_\_

Approximate Date Leave Will Begin: \_\_\_\_\_

Expected Date of Return: \_\_\_\_\_

Family Member's Name (if applicable): \_\_\_\_\_

Relationship: \_\_\_\_\_

1. I understand that the length of leave will not exceed 12 weeks, in total for either this leave alone, or together with any other medical or family related leave(s) taken within the twelve months prior to this leave request; and that this leave will be counted towards my annual FMLA entitlement.
  
2. If my family and medical leave is for purposes of a serious health condition that makes me unable to perform the functions of my job or to care for my spouse, son, daughter or parent who has a serious health condition, I understand that I will be required to furnish WPI with a completed medical certification form attesting to my need for assisting in the caring for the seriously-ill family member, or, if the leave is for my own serious health condition, in order to verify the medical necessity of such care and subsequent leave of absence. This form needs to be filled out and completed no later than 15 days after the employee's request for leave (or as soon as possible in the event of unforeseeable ailment(s)).

Failure to furnish WPI with a completed medical certification form according to this policy may result in a denial of my request for family and medical leave until the certification form is completed and submitted to the Human Resources Office.

3. I understand that I am able to utilize all my available earned sick, vacation and personal time and substitute those earned days as part of my leave.
  
4. I understand that, while I am out on family and medical leave, I will be required to continue to make my health insurance premium payments pursuant to WPI's health insurance policy as if I were still working for WPI. I have made arrangements with the Human Resource Office concerning these payments.

5. I understand that if my leave is for the purposes of the birth of a child or because of my own serious health condition, I understand that I will be required to obtain a medical certification from their health care provider to attest that I am fit to resume work. This certification shall be limited to an evaluation of the particular health condition that resulted in my need for FMLA leave.
6. The Human Resources Office has notified me on whether or not I am to be classified as a “key employee.” If my employment position qualifies me as a “key employee,” I understand that my position may not be available upon my return from leave if WPI determines that the restoration of my employment will cause “substantial and grievous economic injury” to the operations of WPI or would cause long-term economic injury to WPI.
7. I may return to the same or similar position with no loss of employment benefits or status, unless other employees of equal length of service credit and status in the same or similar position have been laid off due to economic conditions or other changes in operating condition affecting employment during such family and medical leave.
8. If my leave of absence is for purposes of caring for a serious health condition of a covered family member or if it is due to my own serious health condition, then I may be required to obtain medical recertification’s during the course of my leave from the health care provider supervising the treatment for such serious health condition concerning the medical necessity for my leave and will also be required to report periodically during the course of my leave on my status and my intent to return to work.
9. I also understand that if I fail to return to work after taking FMLA leave, then I will be required to reimburse WPI for any premium costs of any health insurance coverage paid by WPI during the course of my leave unless the reasons for my inability to return to work are due to a serious health condition incurred by a family member or myself or due to other circumstances beyond my control which prevent me from returning to work with WPI.

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Employee Signature

Date

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Human Resources Signature

Date