



3100 Main, P.O. Box 667517
 Houston, Texas 77266-7517
 (713) 718-8565 FAX (713) 718-8599

CONFIDENTIAL
REQUEST FOR FAMILY OR MEDICAL LEAVE

Print clearly preferably in capital letters and black ink. Complete this form, sign it, and submit it to the Benefits Department to initiate an FMLA request. **Note, the completion of this form and signature of Supervisor DOES NOT INDICATE that your FMLA request is approved. This form may be hand delivered, sent by US Mail, faxed to 713-718-8599 or sent interoffice to HR BENEFITS (MC1120).** [Interoffice mail does not assure confidential handling]

Employee's Name (Please Print)	SSN:
Mailing Address	City State Zip
Campus/Dept	Position
Phone (Day)	Phone (Evening)
Email Address	

Does your spouse work for the Houston Community College System? *(check one)*

Yes No

Reason for taking leave *(check one)*

- To care for my child after birth or placement in adoption or foster care.
- To care for my spouse, child, or parent who has a serious health condition.
- My own serious health condition makes me unable to perform at least one of the essential functions of my job.

For "full time" leave:

Start Date:	End Date:
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For leave to be taken intermittently or on a reduced schedule:

Schedule of Time off requested:

Employee's Signature:

	Date:
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Supervisor's Name: (please print) **Supervisor's Signature** **Date:**

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For HR use ONLY: Date Received: _____ by _____ Tracking ID _____
 HR FORM 104 (rev. 1/16/08)