



FACULTY REQUEST FORM FOR SHORT TERM DISABILITY/ FMLA
This form to be completed thirty (30) days prior to needed leave, or as soon as need for leave is known.
 [See CBA 11.3]

Name: _____	Department: _____
Date Beginning: _____	Date Ending: _____
Attach FMLA Certification of Health Care Provider form or other supporting documentation from your health care provider. (Available from Human Resources, Showalter 314, or call 359-6904 or https://sites.ewu.edu/hr/view/hr-forms/)	<input type="checkbox"/> Rank: _____ <input type="checkbox"/> Tenured <input type="checkbox"/> Probationary <input type="checkbox"/> Special Faculty
Comments/Explanation	
Faculty Signature: _____ Date: _____ Chair: _____ Date: _____ Dean: _____ Date: _____ <input type="checkbox"/> Approved <input type="checkbox"/> Disapproved Human Resources _____ Date: _____ <input type="checkbox"/> Approved <input type="checkbox"/> Disapproved	

Original to: Human Resources, 314 Showalter Hall