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Family Medical Leave
Certification of Qualifying Exigency for Military Leave
Instructions to the Employee: Please complete the following information fully and completely. Several questions below seek a response
as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as “unknown,” or “indeterminate” may
not be sufficient to determine Family Medical Leave Act (FMLA) coverage. Your response is required to obtain a benefit. While you are
not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. You must provide this
form to your employer within 15 calendar days after you have notified your employer of the need for leave.
Employee’s Name: ____
First Middle Last
Name of covered mfver.116 (p)e
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3.Will you need to be absent from work periodically to address this qualifying exigency? ___No___Yes
If so, estimate schedule of leave, including the dates of any scheduled meetings or appointments:__________________
____
Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):
Frequency:______times per______week(s)______month(s)
Duration:______hours______day(s) per event
Part C: If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with
school of childcare providers, to make financial or legal arrangements, to act as the covered military member’s representative before a
federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored
by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate
contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the
individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.
Name of Individual: __________________________________ Title: ____
Organization: ____
Address: ____
Telephone: ( )______________________________________ Fax: ( )____
Email: ____
Describe nature of meeting: ____
____
____

____

Part D
I certify that the information I provided above is true and correct.
__________________________________ ________________________
Signature of Employee Date
Return Completed Form to: Lamar University/Lamar Institute of Technology Human Resources Office
 PO Box 11127 Beaumont, TX 77710 or Fax to (409) 880-8464