

MA PAID FAMILY MEDICAL LEAVE FORM

Employee Name:

HUID:

Appointment Type: ☐ Postdoc ☐ Research Associate

Estimated Leave Start:

Estimated End:

I am requesting the following intermittent leave: Yes ☐ No ☒

If yes, I am requesting the following schedule.

Child's Due Date / Placement Date, if applicable:

Reason for Leave:

- ☐ Birth, adoption, or placement of a foster child
- ☐ For a serious health condition that makes the employee unable to perform the essential functions of their job
- ☐ To care for a family member with a serious health condition
- ☐ To care for a covered service member with a serious injury or illness (employee's spouse, child, parent, or next of kin)
- ☐ For any qualifying exigency arising out of the fact that an employee's family member is on active military duty or call to covered active-duty status

Department Information:

Department Name:

Department Administrator:

Manager/Supervisor Name:

My supervisor is aware of my leave request: Yes ☐ No ☐

A detailed overview of the leave benefits may be found in these summaries:

- For [Postdocs](#)
- For [Research Associates](#)

Signature

Date

Return signed original via email to the **FAS Leaves Office** at leaves@fas.harvard.edu