FAMILY AND MEDICAL LEAVE (FMLA) - REQUEST FORM

Employees are entitled, under the Family and Medical Leave Act (FMLA), to take up to 12 weeks of paid or unpaid job protected leave.

FMLA leave is granted for the following reasons:

1.) For the birth of a child and to care for the new born,
2.) The placement of a child for adoption or foster care and to care for the newly placed child,
3.) To care for an immediate family member (spouse, partner, daughter, son, parent) with a serious health condition,
4.) For an employee who is unable to complete the essential functions of his/her job due to a serious health condition,
5.) For an employee and/or family member that has been called to active duty for "any qualifying exigency" and
6.) 26 weeks of leave to care for a family member that has been injured in the course of active duty.

Submit this request form to your supervisor. Thirty days notice is required when the need for the leave is foreseeable. When advance notice is not practical, this leave request needs to be submitted as soon as is feasibly possible, usually within two working days. ***Requesting FMLA leave or being out sick for more than 3 days does not mean that FMLA is automatically granted.***

SECTION I - TO BE COMPLETED BY THE EMPLOYEE

Employee Name: _____ Department: _____

Job title: _____ Date of Hire: _____

Type of leave: ☐ Continuous ☐ Intermittent (Comment on schedule below)

REASON FOR LEAVE: (mark all that apply)

☐ Birth of child and to care for the child
☐ Care of a spouse/partner with a serious health condition
☐ Care for a child through adoption or foster care
☐ Care of a parent with a serious health condition
☐ Care for a child with a serious health condition
☐ Employee's serious health condition making them unable to work
☐ Inpatient hospitalization
☐ Continuous treatment by a healthcare provider
☐ "Any qualifying exigency" that may exist due to a call to active duty in the armed forces
☐ 26 weeks to care for a family member that has been injured while on active military duty.

Expected start date: _____ Expected date of return: _____

Intermittent Schedule of Leave: _____

ACKNOWLEDGEMENT BY EMPLOYEE

A ***FMLA Medical Certification*** from a health care provider is required to support a request for an employee's own serious health condition or that of an immediate family member.
A ***FMLA Return to Work Certification*** will be required from an employee when returning to work after the employee's own serious health condition.

I elect to use leave in the following order: *(indicate the order and number of hours you elect to use)*

Sick Leave _____ Order/Hours Vacation Leave _____ Order/Hours Compensatory Time _____ Order/Hours Leave without pay _____ Order/Hours

You may be eligible to use up to six weeks Paid Parental Leave (PPL) as part of your FMLA if for birth/adoption of child. Contact HR.

I, acknowledge that the FMLA request is not valid until it has been certified and approved by Human Resources. I also understand the requirement to communicate with my supervisor and Human Resources on an ongoing basis, if there are any changes in my leave request or return to work date.

Employee's Signature: _____ Date of request: _____

SECTION II – TO BE COMPLETED BY EMPLOYEE'S SUPERVISOR

I acknowledge, pending appropriate medical certification, the above employee's request for FMLA.

Supervisor (Print Name)	Supervisor Signature	Date
_____	_____	_____

HR: FMLA approved by: _____ Certification sent, date: _____

FMLA denied for reason: _____