EMPLOYEE MEDICAL/FAMILY LEAVE (FMLA) REQUEST FORM

The purpose of Family and Medical Leave (FMLA) is to provide unpaid, job protected leave to eligible employees for certain medical reasons as mandated in the Family and Medical Leave Act of 1993. An eligible employee is entitled to up to 12 weeks of unpaid leave during the rolling 12-month period (looking backward from the date that the leave commences).

Employee Information

Name: _____ Department: _____

Job Title: _____ Supervisor: _____

Today's Date: ____/____/____ Hire Date: ____/____/____

Status: ____ Full Time ____Part Time

Reason for Requested Leave

I am requesting Family/Medical Leave for the following reason(s) (check all that apply):

____ For birth of my child and/or care for the newborn child
____ For placement of child with me for adoption or foster care
____ To care for my (circle one): spouse, child or parent with a serious health condition
____ A serious health condition that makes me unable to perform the functions of my job
____ Family member on duty or call to active duty status in support of an emergency operation as a member of the National Guard or Reserves
____ Family member is a servicemember with a serious injury or illness
____ Other: (please explain) _____
_____

Duration of Leave

Leave expected to begin: ____/____/____ Leave expected to end: ____/____/____

I request intermittent leave or reduced-schedule leave at the following times:
Schedule: _____
Reason: _____

Concurrent Use of Leave (required)

____I request to use (check all that apply): ___ Paid Vacation ___Sick Hours ___Comp Time

Employee Certification and Signature

I certify that the above information is true and correct to the best of my knowledge

Employee Signature: _____ Date: _____
I can be reached at the following address and phone number during my leave:
_____
_____