

Family and Medical Leave Request Form

Employee: _____ Date: _____

Job Title: _____ Supervisor: _____

SSN #: _____

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons. Submit this request form to your supervisor at least 30 day before the leave is to commence, when practicable. When submission of the request 30 days in advance is not practicable, submit the request as early as is practicable. The employer reserves the right to deny or postpone leave for failure to give appropriate notice when such denial/postponement would be permitted under federal or state law

ELIGIBILITY

1. Counting any periods of time that you worked for the company (whether they were consecutive or not) have you worked for the company for a total of 12 months or more? (If "yes," continue to next question. If "no," stop here.)
 Yes No
2. During the past 12 months, have you worked at least 1,250 hours? (approximately eight months of 40-hour weeks or one year of 25-hour weeks)? (If "yes," continue to next question. If "no," stop here.)
 Yes No

Have you previously received medical or family leave? If yes, provide information below:

Dates of leave: From _____ To _____

Purpose of leave _____

3. Have you taken any intermittent leave?
 Yes No
4. Have you taken time off from scheduled hours?
 Yes No

If "yes," provide details:

REASONS FOR REQUESTING LEAVE:

Leave must be granted for any of the following reasons:

- For a serious health condition that makes it unable for you to perform your job;
- To care for your child, spouse, or parent who has a serious health condition; or
- To care for your child after birth, or for placement after adoption or foster care.

I am requesting leave for the following reason:

Personal serious health condition

Serious health condition of:

Spouse Name: _____

Child Name: _____

Parent Name: _____

Birth of a child

Expected delivery date is: _____

Adoption or placement of a child for foster care

Child's name: _____

Scheduled date of adoption or placement: _____

DATES OF LEAVE REQUESTED:

I request leave from _____ **to** _____

I request intermittent leave according to the following schedule: _____

I request a reduced schedule leave according to the following schedule:

The total number of days of leave that I request is _____.

Do you wish to use Vacation, Sick, or PTO time while on FMLA? Yes No
If YES, how would you like your time disbursed?

EMPLOYEE STATEMENT:

I agree to return to work on _____, If circumstances change such that I will not be able to return to work on that date, I agree to inform my supervisor by submitting a NOTICE TO EMPLOYER OF CHANGES IN APPROVED MEDICAL OR FAMILY LEAVE form. I understand that my benefits will continue during my leave and that I will arrange to pay my share of applicable premiums.

Signature: _____ **Date:** _____

TO BE COMPLETED BY SUPERVISOR

Staff member was hired on _____

He/she started in this department on _____

Staff member is Full-time Part-time

Regular hours are _____ hrs on _____ days of the week for a total of _____ hours per week.

Schedule commenced on _____ (If there was an earlier schedule, list below):

Are there 50 or more staff members at or within 75 miles of the work site where the staff member works? Yes No

Has the workforce been this large for at least 12 months? Yes No

How will the staff member's duties and responsibilities in your unit be handled during his/her leave of absence?

Employee has previously requested family or medical leave on _____

Leave taken from _____ to _____ Total time taken _____

Supervisor: _____ Title: _____

Date: _____ Telephone #: _____

TO BE COMPLETED BY HUMAN RESOURCES

Prior leave requests confirmed: _____

Leave is Approved

Denied for the following reason(s):

Request approved /denied by: _____

Date: _____