FAMILY OR MEDICAL LEAVE REQUEST FORM

INSTRUCTIONS FOR THE EMPLOYEE:

- *Complete your part of the form and submit it to HR 30 days prior to start date of Family Medical Leave.*
- *You will be notified as to whether the leave is approved or not*

Date: _____

☐ **Full Time** ☐ **Part Time**

EMPLOYEE INFORMATION		
Employee Name		**Employee ID Number**
Job Title	**Department**	**Location**
Home Address		**Home Phone #**
City	**State**	**Zip Code**

TYPE OF LEAVE

I hereby request the following type of leave:

☐ **Family leave for the:**

- ☐ **Birth of my son or daughter**
- ☐ **Placement of a child with me for** ☐ **adoption** ☐ **foster care**

Anticipated date of birth or placement: _____

☐ **Family leave to care for a spouse, son, daughter or parent with a serious health condition**

Family member's full name: _____

Relationship to you: ☐ **spouse** ☐ **parent** ☐ **son or daughter** ☐ **other (if applicable)**

☐ **Medical leave for my own serious health condition (specify):** _____

_____

☐ **Servicemember Care**

☐ **Exigency Leave**

PRIOR LEAVE

1. **Have you ever in the past, used Family & Medical Leave** ☐ **yes** ☐ **no**
2. **If so, describe: Dates of Leave: from** _____ **to** _____
3. **Purpose of Leave:** _____

_____

_____

_____

AMOUNT OF LEAVE

1. **I request that the leave be granted for the following period of time:**

   Beginning on (date): _____ **Ending on (date):** _____

2. **I further request that the leave be granted for the following reduced or intermittent leave schedule:**

   _____

   _____

3. **I am required to substitute the following paid leave time, if applicable, to run concurrent with my family or medical leave: Type:** ☒ **Sick** ☒ **Vacation Amount: until paid leave is exhausted.**

EMPLOYEE CERTIFICATION AND SIGNATURE
I hereby certify that the information given above is true and correct to the best of my knowledge. I understand that misrepresentation or omission of the reason for leave or any of the facts supporting the need for leave may result in denial of the leave and will subject me to discipline up to and including termination. **I agree to return to work at the end of my FML or when the stated need for FML ceases to exist. If circumstances change, and I am able to return to work early; or unable to return to work after the FML ending date, I agree to notify my immediate supervisor.** **I understand that if I choose to have my benefits continue during my leave, I must arrange to pay my portion of the premiums.** **Signature: _____ Date: _____**

_____	_____
Supervisor Signature	**Date**

MAINTAIN THIS FORM IN A FMLA CONFIDENTIAL FILE

HR USE ONLY		
Received By:		
Signature		Date
Hire Date	Prior FML Leave Dates ☐ From _____ To _____ ☐ No Prior FML Leave	
Application for leave is ☐ Approved ☐ Denied		
If Denied, Please state reason(s) _____ _____ _____ _____		