EMPLOYEE REQUEST FOR FMLA LEAVE

Name:_____Date: _____

Job Title:_____Employee ID #: _____

Address: _____

Home Phone: _____ Cell Phone #: _____

Supervisor: _____ Supervisor email _____

The Family and Medical Leave Act (FMLA) of 1993 entitles eligible employees to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Under the Family and Medical Leave Act (FMLA), eligible employees are entitled to up to 12 weeks of unpaid, job protected leave for certain family and medical reasons in a 12 month period, OR up to 26 weeks in a 12 month period to care for covered service member with serious injury or illness who is the spouse, son, daughter, parent or next of kin to the employee.

Part-time employees must meet criteria be eligible for FMLA. FMLA may be paid, unpaid, or a combination of paid and unpaid, depending on the circumstances and as specified in FMLA, state law and agency policy.

Employees must meet two lengths of service requirements to be FMLA eligible:

1. Have worked for a total of at least 12 months (52 weeks)
2. Have worked at least 1250 hours during the 12 month period immediately before the date the leave would begin

Employees seeking to use FMLA leave are required to provide 30-day advance notice of the need to take FMLA leave when the need is foreseeable and such notice is practicable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Please indicate the reason for your FMLA Leave (medical certification must be provided within 15 days of the date of initial application).

_____ Your own serious health condition (medical certification attached)
_____ Birth of a child and to care for that child (medical certification attached)
_____ Placement in your home of a child for adoption or foster care (court order attached)
_____ Care of a spouse, domestic partner, child, or parent with serious health condition (medical certification attached)

Name of family member for whom you will provide care :_____
Relationship of family member to you: _____
If family member is your son or daughter, date of birth:_____
Describe care you will provide to your family member and estimate leave needed to provide care:_____

_____ Family member (spouse, child or parent) in military - qualifying exigency

Name of covered military member on active duty or call to active duty status in support of a contingency operation: _____
Relationship of covered military member to you: _____
Period of covered military member's active duty: _
Please check one of the following:
____A copy of the covered military member's active duty orders is attached.
____Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
____I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

_____ Family member (spouse, child, parent or next of kin) in military - caregiver, serious injury or illness of service member

Name of Covered Service member (for whom employee is requesting leave to care):_____
Relationship of Employee to Covered Service member Requesting Leave to Care:_____
Describe the Care to Be Provided to the Covered Service member and an Estimate of the Leave Needed to Provide the Care_____
*Leave requests based on a serious health condition for a military family member must be documented by a United States or Department of Defense (DOD) authorized health care provider or an authorized DOD representative if the provider is unable to make certain military-related determinations as outlined in the FMLA.

Date of Leave Requested (please indicate leave requested)

_____ I request leave from_____to _____
_____ I request intermittent leave according to the following Schedule
_____
_____ I request reduced schedule leave according to the following Schedule
_____

The total amount of leave that I request is: _____

I agree to return to work on_____. The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. If circumstances change such that you will not be able to return to work on that date, you agree to inform your supervisor as soon as practicable.

I hereby acknowledge that failure to return to work at the conclusion of my leave will be deemed a resignation from employment, unless the agency approves a leave extension and records such approval in writing.

I hereby authorize The State Personnel Office to contact my physician to verify the reason for my requested leave or to obtain information concerning this request for leave under the Family and Medical Leave Act.

While on paid leave, agency will continue to make payroll deductions to collect the employee's share of group insurance premiums. While on unpaid leave, you are responsible to make financial arrangements with HR to pay for your coverage and to prevent cancellation of your group insurance. Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.

You may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave if you do not return to work following FMLA leave for a reason other than:

1. the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave;
2. the continuation, recurrence, or onset of a covered service member's serious injury or illness which would entitle you to FMLA leave; or
3. Other circumstances beyond your control.

You may be required to provide a return to work certificate from your provider prior to being restored to employment. Certification must address any work restrictions; indicate whether restrictions are permanent or temporary and the expected date you will return to full duty from the restrictions.

Employee Signature _____

Supervisor Acknowledgement _____