FAMILY/MEDICAL LEAVE REQUEST FORM

Employee:_____ **Date:**_____

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; and up to 26 weeks of unpaid, job-protected leave in a single 12-month period to care for a covered family member who was seriously ill or injured during their active military service. Submit this request form to the Human Resources Department at least 30 days 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 practicable. In most cases, it should be practicable to provide notice of the need for leave either the same day as the need for leave becomes known, or the next business day. The employer reserves the right to delay or deny leave for failure to give appropriate notice when such delay/denial would be permitted under federal law.

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
- To care for your child after birth, or for placement after adoption or foster care
- For a qualifying exigency arising out of your spouse, son, daughter, or parent's active duty or notification of an impending call order to active duty in the armed forces in support of a contingency operation
- To care for your spouse, son, daughter, parent or next of kin recovering from a serious injury

I am requesting leave for the following reason (check one):

☐ My own serious health condition

☐ Serious health condition of:

Spouse Name:_____

Child Name:_____

Parent Name:_____

☐ Birth of a child Expected delivery date:_____

☐ Adoption or placement of a child for foster care

Child's Name:_____

Scheduled date of adoption or placement:_____

☐ A qualifying exigency arising out of active duty or notification of an impending call order to active duty in the armed forces in support of a contingency of:

Spouse Name:_____

Son Name:_____

Daughter Name:_____

Parent Name:_____

☐ Recovery from a serious injury or illness suffered while on active duty in the armed forces of:

Spouse Name:_____

Son Name:_____

Daughter Name:_____

Parent Name:_____

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_____.

Employee Statement:

I certify that the statements made above are true and accurate. I understand that I have an obligation to respond to any questions from my employer designed to determine whether my absence is potentially FMLA-qualifying. Furthermore, I understand that if I fail to respond to any reasonable inquiry by my employer regarding this leave request, the employer may deny my FMLA leave request if the employer is unable to determine whether the leave is FMLA-qualifying.

Signature:_____ **Date:**_____

Note: All requests for medical leave involving a serious health condition (including maternity) must be accompanied by a completed **Certification of Health Care Provider**.