# Family and Medical Leave Act (FMLA) Request Form

**To be completed by employee**

| Employee Name | Department | Phone Number |
|---|---|---|
| Job Title | | Employee ID |
| ☐ Initial Application | Home Phone # | |

| *Reason for Leave of Absence* | *Answer all:* | Yes | No |
|---|---|---|---|
| ☐ Own illness (not work related) | Do you have dependent medical insurance? | ☐ | ☐ |
| ☐ Care for ill parent/spouse/child | Do you have any supplemental insurance? | ☐ | ☐ |
| ☐ Other (specify) | Are you currently on another leave? | ☐ | ☐ |
| ☐ Pregnancy disability | Have you or are you filing a disability claim? | ☐ | ☐ |
| ☐ Care for newborn/adopted child (Date of Placement) | | | |

| Requested start date | Anticipated end date | Requested intermittent or reduced work schedule |
|---|---|---|
| | | |

*An FMLA leave of absence is a leave without pay. Paid leave (using accrued PTO time) shall be substituted for the unpaid leave in accordance with the Family Medical Leave Act Policy.*

| I understand that I am required to use accrued paid time off until leave concludes or accrued balance is depleted. Below is an estimate of paid time off available in my account. | | Date Begins (mm/dd/yy) | Date Ends (mm/dd/yy) |
|---|---|---|---|
| | Accrued PTO leave | | |
| Employee Signature | | Date | |

I understand that I am required to complete a FMLA Leave Certification of Health Care Provider form and submit the form to Human Resources within 15 days of FMLA leave. I understand that if my leave is approved, my time away from work will be charged against my 12 week leave maximum under FMLA. Upon approval of this requested leave, I am required to utilize all paid time available to me prior to going into an unpaid leave status. In the event that I go into an unpaid status while on leave, I understand that I must contact Human Resources to make arrangements to pay my portion of my insurance premiums.

I request the following forms for my FMLA leave of absence:

1. Certification of Health Care Provider: This form is to be completed by either my health care provider (if this leave is for my own serious medical condition) or by my family member's health care provider (if this leave is for the serious health condition of a spouse, parent, or child). My physician must complete the entire form. Failure to complete this form my delay or prevent my leave approval.
2. Continuation of Benefits While on FMLA Leave: This is an agreement between my employer and myself to continue my benefits while on FMLA leave and a financial arragement for my portion of health care premiums.
3. Notification of FMLA Status (Approved/Denial): This is to notify me that my employer is designating the leave as FMLA leave and to inform me in writing of the specific expectations and obligations required by my employer under FMLA.
4. Request to Return From FMLA Leave: I should fill out the top portion of the form, notifying Human Resources of the date of my return. For my own serious health condition, the bottom portion of the form (fitness-for-duty certification) should be filled out by my Health Care Provider and returned to Human Resources on the day I return to work from FMLA leave.

I understand that the Certification of Health Care Provider form should be returned to Human Resources within 15 days. If I am not able to return the form within the allowed timeframe, I will contact Human Resources for assistance.

If this information is not received in the required timeframe, my leave will be considered unauthorized.

| ______________________ | ______________________ |
|---|---|
| Print Name | Employee Signature |