FAMILY OR MEDICAL LEAVE REQUEST FORM

INSTRUCTIONS FOR THE EMPLOYEE

- Complete the form and submit to appropriate supervisor / location director.
- You will be notified as to whether the leave is approved or not.

EMPLOYEE INFORMATION

Employee Name:____Date Requested: ______________________

Position:____________________________ Program|Location:_______________________________________

TYPE OF LEAVE *I hereby request the following type of leave*

PARENTAL BONDING LEAVE [*available to **Benefits Eligible** Staff*]

Parental Bonding, Medical or FMLA *Family Medical Leave Act* **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:_______________________

NOTE: *Short Term Disability Claim to be initiated by a covered Female Employee with an expectant birth.*

***FAMILY MEDICAL LEAVE** [if eligible] **Additional Medical Certification will be required for these FMLA Leave Requests*

- ○ 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): ____
- ○ Service-member Care
- ○ Exigency Leave

AMOUNT OF LEAVE *ALL MEDICAL/PARENTAL LEAVE RUNS CONCURRENTLY WITH SCHEDULED HOLIDAYS, SUMMER BREAK & FMLA LEAVE *AS APPLICABLE*

(1) I request that the leave be granted for the following period of time:

Beginning on (date):____________________________ Ending on (date):____________________________

FMLA Eligible only:

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

____

**I recognize that my accrued leave banks will be paid out during any FMLA leave [*except in the case that I am receiving disability or W/C payments] and when exhausted, my leave will be unpaid.*

NOTE: Health Insurance premiums are automatically deducted while in a pay status. Payment is required by employee during non-pay status.

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 mis-representation 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 could result in disciplinary action, up to and including the release of my employment.

Signature:____Date:___________________________

Supervisor's Signature:______________________Title:_______________________________ Date:_________

MAINTAIN THIS FORM IN A CONFIDENTIAL MEDICAL FILE

OFFICE USE ONLY Leave Approved? ☐ Yes ☐ No

For what period___________________Expected Return Date:_____________Parental Bonding Paid Leave thru:_____________________

Additional Leave, if eligible:_________________________ STD pay offset, if applicable:________________________________

Medical Certification / Birth Certificate Requested:____________Returned:____________Notice of Leave Approval to Employee:__________

cc> Employee Payroll/HR Signature:___________________________ Date:_________

Last updated: August 2018