Family and Medical Leave Act (FMLA) Request Form

To be completed by employee

Employee's Name	Department	Phone Number
Job Title		Employee ID

☐ Initial Application Home Phone #:

Reason for Leave of Absence
- ☐ Own illness (not work related)
- ☐ Care for ill parent/spouse/child
- ☐ Other (specify)
- ☐ Pregnancy disability
- ☐ Care for newborn/adopted child (Date of Birth/Placement)

Answer all:

	Yes	No
Do you have company medical insurance?	☐	☐
Do you have company dental insurance?	☐	☐
Are you currently on another leave?	☐	☐
Have you or will you be filling a Disability insurance claim?	☐	☐

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 sick time or vacation hours) 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. Hours		Date Begins (mm/dd/yy)	Date Ends (mm/dd/yy)
	Accrued sick leave		
	Accrued vacation leave		
Employee's 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 before my leave commences. 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 health 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 health 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 this entire form. ***Failure to complete this form may 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 arrangement for my portion of health care premiums.

3. Notification of FMLA Status (Approval/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