Central Massachusetts Collaborative

FMLA REQUEST FORM

To request leave on the basis of the Family and Medical Leave of Act (FMLA), please complete the following request form and submit to the Central Office at least thirty (30) days prior to leave (unless leave is unforeseen, in which case submit the form as soon as practical).

Employee Name (print clearly):____

School/Program: ________________________________**Position**: ____

Address and Phone Number: *(include number and street, apartment/unit number, city, state, zip code)*

____

Phone: __________________ **Personal email address:** ____

Requested Leave Start Date: ______________________ **Estimated End Date:** __________________________

The reason for this FMLA leave request is (select the most appropriate box):

- ❑ Birth of a son or daughter and to care for the newborn child.
- ❑ Placement with the employee of a son or daughter for adoption or foster care.
- ❑ To care for the employee's spouse, son, daughter or parent with a serious health condition.
- ❑ A serious health condition that makes the employee unable to perform the functions of the employee's job.
- ❑ A qualifying exigency arising out of the fact that the employee's spouse, son, daughter or parent is a military member on covered active duty (or has been notified of an impending call or order to covered active duty status).
- ❑ To care for a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent or next of kin of the covered service member.

Time off work is expected to be (select the most appropriate box):

- ❑ For a continuous block of time (several continuous days, weeks or months off work).
- ❑ For a reduced work schedule (change in work schedule needed—fewer hours per day or fewer hours per week).
- ❑ On an intermittent basis (periodic time off that is not usually expected to be the same days or time off from week to week; examples may be time off for flare-ups of a medical condition and/or for ongoing medical treatment/appointments).

Additional information about employee FMLA rights and responsibilities will be provided to you in writing within five business days after receipt of this notice (unless already provided).

Determination of eligibility for leave under the FMLA, and/or additional documentation or clarification of documentation, may be required prior to making a final FMLA determination to approve or deny an FMLA leave request. Please contact Human Resources with any questions.

HEALTH INSURANCE\/BENEFIT PAYMENT OPTIONS:
If your leave request is approved, your options include:

- ❑ **Regular Payroll Deductions**: If your paid leave covers the ENTIRE period of the leave (is sick, personal or vacation), regular deductions will be made from your regular paycheck. If not, you must pay CMC directly.
- ❑ **Self-Pay:** I will make payments made out to CMC and send them to Central Office by the 1st of each month.
- ❑ I am not currently enrolled in CMC sponsored Health Insurance/Benefits

A minimum of a two (2) day notice prior to the return date is required if restrictions exist.

Employee Signature: ____ **Date:** ______________________

CMC USE ONLY: Date received: _______________ FMLA Eligibility Notice sent: ______________