

## FAMILY MEDICAL LEAVE – REQUEST FORM

Today's Date: \_\_\_\_\_

Employee's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone (w) \_\_\_\_\_ (h) \_\_\_\_\_

Supervisor's Name (please print): \_\_\_\_\_ Phone (w) \_\_\_\_\_

### Reason for Requesting Leave (please check one):

\_\_\_\_\_ Serious health condition of self *(Medical Certification required to be submitted to HR within 15 days of leave request)*

\_\_\_\_\_ Birth of child

\_\_\_\_\_ Placement of a child for adoption or foster care

\_\_\_\_\_ A serious health condition of a family member for which you are needed to provide care *(Medical Certification required to be submitted to HR within 15 days of leave request)*

\_\_\_\_\_ Any qualifying exigency\* due to a spouse, child, or parent who is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.

\*Subject to the United States Department of Labor's definition of "qualifying exigency."

\_\_\_\_\_ A spouse, child, parent or next of kin is receiving medical treatment for, or recuperating from, a serious injury or illness incurred while serving in the U.S. military. Up to 26-weeks of unpaid leave may be available for this FMLA request.

#### **If leave is being requested to care for a family member;**

**1) What is the relationship to employee** (please check below):

\_\_\_ Child (under 18) \_\_\_ Child (over 18) \_\_\_ Spouse \_\_\_ Parent \_\_\_ Parent-in-law \_\_\_ Grandparent

**2) What specific care will you provide?**

### The type of leave I am requesting is:

Single Occurrence     Intermittent Leave     Work Schedule Limitations     Combination Single Occurrence to Intermittent

#### **Estimated Duration of Leave:**

Single occurrence: Start Date: \_\_\_\_\_ Expected Return Date: \_\_\_\_\_

Intermittent leave: Start Date: \_\_\_\_\_ Anticipated End Date: \_\_\_\_\_

Anticipated absence frequency: \_\_\_\_\_

Anticipated time off for each absence \_\_\_\_\_

Work Schedule Limitations/reduced hours request: \_\_\_\_\_

**Please Complete Signatures and Acknowledgment on Following Page**

**Required Signatures:** By signing below I agree I have received a copy of the Family Medical Leave Act Rights & Obligations, have reviewed it and received clarification if there were questions.

Employee signature: \_\_\_\_\_

Date: \_\_\_\_\_

Supervisor signature: \_\_\_\_\_

Date: \_\_\_\_\_

HR Rep signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **STATEMENT OF YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993**

The Family and Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to “eligible” employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least 1 year and for 1,250 hours over the previous 12 months, and if there are at least 50 staff members within 75 miles. Calculation of the 12-month period is according to the rolling calendar method.

### **REASONS FOR TAKING LEAVE:**

Unpaid leave must be granted for any of the following reasons:

- To care for an employee’s child after birth, or placement of adoption or foster care;
- To care for an employee’s spouse, son or daughter, or parent who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform his or her job.
- Any qualifying exigency\* due to a spouse, child, or parent who is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.

\*Subject to the United States Department of Labor’s definition of “qualifying exigency.”

A 26-week period of unpaid leave may be available to an FMLA-eligible employee whose relative is receiving medical treatment for, or recuperating from, a serious injury or illness incurred while serving in the U.S. military. The employee must qualify for FMLA leave, and must be the spouse, child, parent, or next of kin of the covered servicemember.

At the employee’s or the employer’s option, certain kinds of paid leave may be substituted for unpaid leave.

### **ADVANCE NOTICE AND MEDICAL CERTIFICATION:**

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- Employees ordinarily must provide 30 days’ advance notice when the leave is foreseeable.
- An employer may required medical certification to support a request for leave because of a serious health condition and may required second or third opinions (at the employer’s expense) and a fitness-for-duty certification to return to work.

### **JOB BENEFITS AND PROTECTION:**

- For the duration of FMLA leave, the employer must maintain the employee’s health coverage under any group health plan.
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

### **UNLAWFUL ACTS BY EMPLOYERS**

The FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under the FMLA, and
- Discharge or discriminate against any person for opposing any practice made unlawful by the FMLA or for involvement in any proceeding under or relating to the FMLA.

### **ENFORCEMENT:**

- The US Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring civil action against an employer for violations.
- The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

### **FOR ADDITIONAL INFORMATION:**

Contact the nearest office of the Wage and Hour Division, Department of Labor or the US Government.