Family and Medical Leave Request

Expires

Date: _____

Please Note: Request for Family or Medical Leave must be made, if practical, at least 30 Days prior to the date the requested leave is to begin. Please return to your supervisor.

Employee Name _____ **Title/Position** _____

Department _____ **Reports to** _____

Status: ☐ **Full Time** ☐ **Part Time** ☐ **Temporary** **Employee Payroll No.** _____

Hire Date _____ **Length of Service** _____

I request a family or medical leave for one or more of the following reasons:

☐ Because of the birth of my child and in order to care for him or her. Submit copy of birth certificate when available.
Expected date of birth _____ Actual Date of birth (if applicable) _____
Leave to start _____ Expected return date _____

☐ Because of the placement of a child with me for adoption or foster care. Submit certified legal record of placement when available.
Date of placement _____
Leave to start _____ Expected return date _____

☐ In order to care for my spouse, child, or parent, who has a serious health condition. Submit medical documentation.
Leave to start _____ Expected return date _____

☐ For a serious health condition that makes me unable to perform my job. Submit medical documentation.
Leave to start _____ Expected return date _____

☐ Proposed intermittent or reduced day schedule, if applicable. May be subject to supervisor / employer's approval.
_____
_____
_____

Have you taken a family or medical leave in the past 12 months? ☐ Yes ☐ No If yes, when and how many days? _____

I understand and agree to the following:

1. I have been employed at this company for at least 12 months.
2. During the previous 12 months I have worked at least 1,250 hours.
3. If I fail to return to work after the leave for reasons other than the continuation, recurrence or onset of a serious health condition that would entitle me to Medical Leave or other circumstances beyond my control, I may be financially responsible for the medical insurance premiums that the company paid while I was on leave, depending on my company's policy.
4. This leave may be unpaid, unless it is company policy to be paid; or payment may occur under a company disability or other insurance plan under which I may be covered.
5. I may be required to use my paid vacation, personal or sick leave as part of my 12 weeks of leave.
6. After 12 weeks of leave, if I do not return to work or contact my supervisor or manager on or before my expected date of return, the company may assume that I have abandoned my job.

Employee Signature _____ **Date** _____

Leave Processing

Has employee been at company for at least 12 months? ☐ Yes ☐ No

Explain: _____

Has employee worked at least 1,250 hours during the previous 12 months? ☐ Yes ☐ No

Explain: _____

Manager / Supervisor Signature _____ **Date** _____

Has employee submitted required documentation? ☐ Yes ☐ No

Explain: _____

Division Director's Signature _____ **Date** _____

Payroll Instructions

☐ With Pay From: _____ To: _____

☐ Without Pay From: _____ To: _____

Additional Instructions:

_____

_____

_____

_____

_____

_____

_____

☐ **Leave Approved** ☐ **Leave Denied** ☐ **Preliminarily**
(If leave is denied, employer must give written notice of reasons for denial. Copy of notice attached.)

EXECUTIVE DIRECTOR'S SIGNATURE: _____

DATE SIGNED: _____