FAMILY OR MEDICAL LEAVE REQUEST FORM

INSTRUCTIONS FOR THE EMPLOYEE

- Complete the form and submit to HR.
- You will be notified as to whether the leave is approved or not.

EMPLOYEE INFORMATION	
Employee Name	
Employee Number	Title

TYPE OF LEAVE

I hereby request the following type of leave:

- ☐ Family 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:_____
- ☐ 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): _____
  _____
- ☐ Servicemember Care
- ☐ Exigency Leave

AMOUNT OF LEAVE

(1)I request that the leave be granted for the following period of time:
Beginning on (date):_____ Ending on (date):_____
(2)I further request that the leave be granted for the following reduced or intermittent leave schedule:
_____
(3)I would like to substitute the following paid leave time, if applicable, during my family or medical leave:
Type:_____ Amount:_____

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 misrepresentation or omission of the reason for leave or any of the facts supporting the need for leave will result in denial of the leave and will subject me to discipline up to and including termination.

Signature:_____Date:_____

MAINTAIN THIS FORM IN A FMLA CONFIDENTIAL FILE

HR USE ONLY		
Leave Approved? ☐ Yes ☐ No For what period?_____	Expected Return Date	
The following paid leave will be substituted:	Insurance premium to be paid as follows	
Remarks:		
Signature	Title	Date