

# Family and Medical Leave Request Form

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

Job Title: \_\_\_\_\_ Supervisor \_\_\_\_\_

SSN #: \_\_\_\_\_

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons. Submit this request form to your supervisor at least 30 day before the leave is to commence, when practicable. When submission of the request 30 days in advance is not practicable, submit the request as early as is practicable. The employer reserves the right to deny or postpone leave for failure to give appropriate notice when such denial/postponement would be permitted under federal or state law

## ELIGIBILITY

1.  Yes  No

Counting any periods of time that you worked for the company (whether they were consecutive or not) have you worked for the company for a total of 12 months or more? (If "yes," continue to next question. If "no," stop here.)

2.  Yes  No

During the past 12 months, have you worked at least 1,250 hours? (approximately eight months of 40-hour weeks or one year of 25-hour weeks)? (If "yes," continue to next question. If "no," stop here.)  
Have you previously received medical or family leave? If yes, provide information below:

Dates of leave: From \_\_\_\_\_ To \_\_\_\_\_

Purpose of leave \_\_\_\_\_

3.  Yes  No

Have you taken any intermittent leave?

4.  Yes  No

Have you taken time off from scheduled hours?

If "yes," provide details: \_\_\_\_\_

## REASONS FOR REQUESTING LEAVE:

Leave must be granted for any of the following reasons:

- For a serious health condition that makes it unable for you to perform your job;
- To care for your child, spouse, or parent who has a serious health condition; or
- To care for your child after birth, or for placement after adoption or foster care.

**I am requesting leave for the following reason:**

**Personal serious health condition**

**Serious health condition of:**

Spouse Name: \_\_\_\_\_

Child Name: \_\_\_\_\_

Parent Name: \_\_\_\_\_

**Birth of a child**

Expected delivery date is: \_\_\_\_\_

**Adoption or placement of a child for foster care**

Child's name: \_\_\_\_\_

Scheduled date of adoption or placement: \_\_\_\_\_

**DATES OF LEAVE REQUESTED:**

I request leave from \_\_\_\_\_ to \_\_\_\_\_

I request intermittent leave according to the following schedule: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I request a reduced schedule leave according to the following schedule:

\_\_\_\_\_  
\_\_\_\_\_

The total number of days of leave that I request is \_\_\_\_\_.

**EMPLOYEE STATEMENT:**

I agree to return to work on \_\_\_\_\_. If circumstances change such that I will not be able to return to work on that date, I agree to inform my supervisor by submitting a NOTICE TO EMPLOYER OF CHANGES IN APPROVED MEDICAL OR FAMILY LEAVE form. I understand that my benefits will continue during my leave and that I will arrange to pay my share of applicable premiums.

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

**TO BE COMPLETED BY SUPERVISOR**

Staff member was hired on \_\_\_\_\_

He/she started in this department on \_\_\_\_\_

Staff member is  Full-time  Part-time

Regular hours are \_\_\_\_\_ hrs on \_\_\_\_\_ days of the week for a total of \_\_\_\_\_ hours per week.

Schedule commenced on \_\_\_\_\_ (If there was an earlier schedule, list below):

Are there 50 or more staff members at or within 75 miles of the work site where the staff member works?

Yes  No

Has the workforce been this large for at least 12 months?  Yes  No

How will the staff member's duties and responsibilities in your unit be handled during his/her leave of absence?

\_\_\_\_\_  
\_\_\_\_\_

Employee has previously requested family or medical leave on \_\_\_\_\_

Leave taken from \_\_\_\_\_ to \_\_\_\_\_ Total time taken \_\_\_\_\_

Supervisor: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**TO BE COMPLETED BY HUMAN RESOURCES**

Prior leave requests confirmed: \_\_\_\_\_

Leave is  Approved

Denied for the following reason(s): \_\_\_\_\_

\_\_\_\_\_

Request approved /denied by: \_\_\_\_\_

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