

# Family and Medical Leave Request

Expires 12/31/2011

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:** \_\_\_\_\_