REQUEST FOR FAMILY MEDICAL LEAVE (FMLA)

To be eligible for FMLA leave the employee must have been employed by the state for at least 12 months; and have worked at least 1,250 hours during the 12 months prior to the commencement of FMLA leave. Employees are expected to give as much advance notice as possible when requesting FMLA leave and to make all reasonable efforts to minimize the disruption caused by their absence. The employee is required to substitute any available accrued paid leave for any part of the applicable leave provided under the Family Medical Leave Act.

Name: ____

Home Address: ____
(City) (State) (Zip)

Telephone: ______________________________ **Work Telephone:** ____________________________

Department: _____________________________ **Supervisor:** ________________________________

I am requesting FMLA as: (check one)

- ☐ **Continuous leave** under the care of a licensed practitioner during a prolonged period of incapacity or Convalescence due to a catastrophic illness, or
- ☐ **Intermittent leave or reduced work schedule** for a chronic, severe medical condition requiring recurrent treatment by a licensed practitioner.

The employee is required to furnish a written statement from the licensed practitioner to substantiate the need for intermittent leave and whether leave will be taken as needed or on a set schedule.

Purpose of Leave (Check one)

- ☐ Childbirth/Adoption/Foster
- ☐ Child Employee's Personal Illness/Type of Illness
- ☐ Care for a Seriously Ill Family Member (Employee's Spouse, Child or Parent)

  Relationship: ____

  Type of Care required ____

- ☐ Care for a Covered Service Member
- ☐ For Qualifying Exigency for Military Family Leave

FMLA Beginning Date _________________________ **FMLA Ending Date** _________________________

An employee who has been on FMLA leave for more than 3 consecutive days due to his or her own serious health condition is required to provide **medical certification** of fitness for duty before returning to work.

I certify that the information above is accurate. I understand that I may have to provide necessary medical documentation for any period of FMLA requested and that I will need to notify my department and/or Human Resources immediately if any of the information above should change.

Employee ____ Date ______________________________

HR Representative______________________________________ Date ____________________________

Return completed form and proper documentation to the Human Resource Department