

EMPLOYEE FMLA REQUEST FORM

TO BE COMPLETED BY EMPLOYEE:

Name: _____

Division/Department: _____

Job Classification: _____

Home/Cell Phone: _____ Work Phone: _____
(Required)

Home Mailing Address: _____
(City, State, Zip Required)

Date Of Birth/Adoption (If Applicable): _____

If For A Family Member, State Their Name And Your Relationship To Them:

The Basis For The FMLA Request Is:

- Birth of child, and/or care of newborn, adopted or foster care child
- Care of a qualifying family member with Serious Health Condition
- Employee's own Serious Health Condition
- Military-Related Leave

The attached documentation supporting this request is a Certification from:

Health Care Provider Adoption/Foster Military

I seek _____ hours, days or weeks (circle one)

_____ In a block of time or _____ intermittently, and

- Please use:
- Sick time first, then vacation, then unpaid leave
 - Vacation first, then sick time, then unpaid leave
 - Unpaid leave
 - Other _____

TO BE COMPLETED BY DIVISION:

Payroll Clerk

Date Received

Date Sent to HR

- Employee has worked for the 12 prior months
- Employee has met the 1,250-hours-worked requirement
- Employee has not used up his or her yearly FMLA leave entitlement

Other comments, if any: _____
