Application for Family Medical Leave

Employee Contact Information: (Please print clearly using a black pen.)

Name:____ Employee Number: ______________________

MailingAddress:____

Home /Cell Telephone: ____ Work Ext.: _____________________

Position: ____ Dept/Unit: ___________________ Facility: __________________

Immediate Supervisor's Name: ____ Ext.: ______________________

Date of Anticipated Leave:

Start: ____ **Return to Work:** ______________________________________

Reason for Leave of Absence: Please Explain. (If leave is to care for a family member, please explain the care you will provide.)

( ) Employee / Self - Serious Medical Condition

( ) Birth of child and to care for child within 12 months of the date of birth

( ) Adoption or foster care of a child within 12 months of the date of placement.

( ) Family Member – Serious Medical Condition

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Name & Relationship of Family

Are you requesting leave on an intermittent or reduced leave schedule? ( ) No ( ) Yes If yes, please give schedule below of when you anticipate you will be unavailable for work.

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Please read carefully and sign. Your signature indicates that you have read, understood, and agree to the statements below:

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless I have been approved for an extension under the DCH Health System's Leave Policy.

To facilitate payment of the insurance benefit premiums, I authorize deductions from my paycheck for the elected coverage and further authorize catch up deductions if I fall behind on my premium payments. If I am unable to return to work at the conclusion of my leave, I will be billed for any unpaid premium benefits that have accrued during my leave which I may re-pay by personal check or money order.

( ) By checking this box, I agree that I have notified my immediate supervisor / manager of this request for Family Medical Leave and given a 30-day notice.

Employee Signature: ____ Date: __________________________

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*Note: An employee requesting leave regarding their own health condition or the health condition of a spouse, child or parent, **must** submit a Certification of Health Care Provider Form completed by the attending physician within **15 days of the initial request**. (The Certification of Health Care Provider Form is enclosed.) **If possible, please submit both the Application for Family Medical Leave and the Certification of Health Care Provider Form together**.*

Return all appropriate forms to the facility listed below:

[ ] **DCH Health System**
Employee Health– Leave Management
809 University Blvd. East
Tuscaloosa, AL 35401
Telephone Number: (205) 750-5033
Fax Number: (205) 343-8852

** Attention: For fax submissions, this sheet may be used as a cover sheet. **

Rev: 12/1/2011