CITY OF SACO

Family and Medical Leave Request Form

Employee: _____

Date:_____

Job Title:_____ Department:_____

Supervisor:_____

Social Security Number:_____

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) up go 12-weeks of unpaid, job-protected leave for certain family and medical reasons. Submit this request form to your supervisor at least thirty (30) days before the leave is to commence, when practicable. When submission of the request thirty (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/postponing would be permitted under federal or state law.

ELIGIBILITY

1. Counting any periods of time that your worked for the city (whether they were consecutive or not), have worked for the City for a total of 12 months or more? Yes or No

2. During the past 12-month, have you worked at least 1,250 hours? (approximately eight (8) months of 40-hour weeks or one year of 25-hour week)?
   Yes or No

3. Have you previously received medical or family leave? Yes or No
   If yes, provide information below:

   Date of leave: _____

   From _____ to _____

   Purpose of leave:_____

4. Have you taken any intermittent leave? Yes or No
   Have you taken time off from scheduled hours? Yes or No

If "yes," provide details:

REASON 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 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:

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 Department Head as soon an possible. I understand that my benefits will continue during my leave and that I will arrange to pay my share of applicable premiums.

Signature:_____ Date:_____