HALLIBURTON

REQUEST FOR FAMILY AND MEDICAL LEAVE NOTIFICATION FORM

The Family and Medical Leave Act allows eligible employees to miss work intermittently or to take a leave of absence during a 12-month period for certain qualifying medical conditions for yourself and family or military reasons for family members. **This notification form must be completed in its entirety by you, the employee, and submitted to the Medical and Disability (M & D) Department**. This form should be submitted in advance of the requested effective date of the leave, at least 30 days in advance of the leave, if the leave is foreseeable. If the leave is was unforeseen or is less than 30 days in the future, you must complete this form as soon as you become aware of the need for leave. Failure to provide such notice may result in the delay of leave or denial of the leave request.

Name: ___________________________________ **Employee #:**________________**Date:**___________

PSL/Location: ___________________________ **Supervisor:** __________________________________

Desired Start Date of the leave: _________________ **Absence Type:** ***Intermittent or Continuous***

Anticipated return to work date and/or duration: ____

TYPE OF LEAVE (circle one): Paid Leave *(You wish to use vacation hours while out or will qualify for MLOA pay)*
Unpaid Leave *(You do NOT wish to use vacation hours while out)*

This is notice that I am requesting leave pursuant to the Family and Medical Leave Act for: (check one)

______ The birth of and/or in order to bond with a newborn;

______ The placement of a child for adoption or foster care;

______ Serious health condition, to care for a spouse, child or parent;

______ Serious health condition, to care for a spouse, child, parent or next of kin (military reasons)

______ Military Service Exigency (requires a copy of military orders)

______ Serious health condition, for yourself*

Any requested LOA based on a Serious Health Condition, whether it involves the eligible employee* or a family member, must be supported by written medical certification provided by the treating physician or health care provider. The *Health Care Provider Certification Form* must be completed and returned to the M & D Department within **15 calendar days** of the requested leave start date.

Employee, explain the circumstances requiring leave: ____

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Employee Signature: ______________________________________ **Date:** _______________________

Contact Number: _________________________ **Alternate Contact Number:** _____________________

*****_If you will be applying for benefits under Halliburton's Medical Leave of Absence (MLOA) Policy because you need to miss work continuously for a serious health condition for yourself, you should **not** complete this form but rather the MLOA application. Please call the M & D Department to have an MLOLA application sent to you. If you are missing intermittently due to a serious health condition for yourself please do complete this form and the Healthcare Provider Form and submit to the M & D Department._