THE CITY OF AKRON

REQUEST FOR FAMILY AND MEDICAL LEAVE

Please see the City of Akron's FMLA Policy for an explanation of your rights and benefits.

The City of Akron is asking that you complete this request form if you are requesting leave because of the birth of the child and/or to care for the newborn child, for placement with you of a child for adoption or foster care, for your own serious health condition that makes you unable to perform the essential functions of your job, to care for a qualifying family member with a serious health condition, or to care for a qualifying family member recovering from a serious illness or injured while on active duty in the military. If your request is for leave related to your own or a qualifying family member's serious health condition or for military family leave, you will also be asked to submit a completed certification form.

If you are requesting family military leave because of a qualifying exigency, you do not need to complete this form. Instead, please contact Employee Benefits or download from the City's Intranet the "Certification of Qualifying Exigency For Military Family Leave" (Family and Medical Leave Act) form.

Employee Name: ______________________ ID Number: ______________

Address: ______________ ______________ ______________
Street/Box City Zip Code

Home Phone: ______________ Work Phone: ______________

Date: ______________ Date of Hire : ______________

Division: ______________ Position: ______________

Scheduled #Days/Week ______________ Scheduled #Hours/Week: ______________

If different than above, I can be reached at the following address and/or telephone number during my leave:

____

I REQUEST A FAMILY/MEDICAL LEAVE FOR THE FOLLOWING REASON:

☐ The birth of a child and in order to care for that child, expected delivery date ____________

☐ Adoption or placement of a child with you for foster care, child's name ______________

Scheduled date of adoption/placement: ____________ *(Note: You must submit documentation of the adoption/ foster care placement)*

☐ My own serious health condition that makes me unable to perform the essential functions of my job;

☐ Due to a serious health condition, I am needed to care for my: ☐ spouse ☐ parent ☐ child

Name of Family Member: ______________ If a son or daughter, list age: ____________

☐ To care for a spouse, son, daughter, parent, or next of kin recovering from a serious injury or illness while on active duty in the armed forces:

Name of Family Member: ______________ Relationship: ______________

Have you taken Family /Medical Leave in the past? ☐ Yes ☐ No

List most recent leave date(s): ____

Does your spouse work for the City of Akron? ☐ Yes, name______________________ ☐ No ☐ N/A

Are you requesting consecutive full-time leave? ☐ Yes ☐ No

I request consecutive full-time leave: from ____________ to__________

Are you requesting intermittent/reduced schedule leave? ☐ Yes ☐ No

I request intermittent/reduced schedule leave: from________ to__________

Why is it medically necessary for you to have intermittent or reduced schedule leave?

Provide a list of dates, times, or schedule that you are requesting leave:

NOTE: When the need for FMLA leave is foreseeable, you must provide at least 30 days advance notice. If it is not possible to give 30 days notice, you must provide notice as soon as practicable. If you fail to provide 30 days notice for foreseeable leave with no reasonable excuse for the delay, the leave request may be denied or delayed. When the need for leave is not foreseeable, notice must be given as soon as practicable, generally not later than one or two days after the need for leave is known.

CERTIFICATION: I certify that the leave/absence requested above is for the purpose indicated. I understand that falsification or submission of fraudulent information may be grounds for discipline up to and including termination.

Employee Signature____ Date______________

Dept. Head/Div. Manager Signature_____________________________________Date____________

NOTE: Your signature indicates that you have received the "Request". You must send this form to Employee Benefits IMMEDIATELY for further processing and final approval.

For Employee Benefits Processing Only:	
Request approved/denied by: _______________________ Date: ________________	☐ Eligible ☐ Not Eligible, reason ______________________________________ ☐ Eligible Pending Medical Certification ☐ Eligible Pending Other Information, _________________________