Request for FMLA Leave of Absence

Notification Requirements: Employees intending to take Family and Medical Leave Act (FMLA) leave must generally provide 30 days' notice prior to the start of expected leave. Failure to provide 30 days' notice may result in denial of FMLA leave until proper 30 days' notice is provided.

Employee Name: _____ Last 4 Digits of SS#: _____

I request this leave of absence for the period and reason indicated:

To Begin: _____ To End: _____

Reason:

- ❑ Birth of my son or daughter
  Please provide expected date of birth _____ or actual date of birth _____
- ❑ Placement of a son or daughter with me for adoption or foster care
  Please provide expected date of placement _____ or placement date _____
- ❑ Care for my spouse, son, daughter or parent who has a serious health condition. Please provide name and relationship to you of person with serious health condition, and the nature of the illness, injury, impairment or physical mental condition:

  _____

  _____
- ❑ Because of my own serious health condition which makes me unable to perform my job. My leave of absence will be taken:
  ❑ in a single block of time ❑ on an intermittent or reduced leave schedule

  If choosing an intermittent or reduced leave schedule, specify below the requested leave schedule and reason for it (include whether schedule is necessary because of planned medical treatment)

  _____

  _____

In the event that my leave of absence is due to my own serious health condition, I agree to provide two (2) business days notice regarding my decision to return to work or request an extension of my leave, whichever is applicable.

I certify that the information contained on this form is true and complete. I understand that any misrepresentation or attempt to fraudulently take FMLA leave is cause for disciplinary action, including dismissal.

Employee Signature: _____ Date: _____

For Management Use Only

Check all that apply:

- ❑ On behalf of the company, I conditionally approve this request for leave pending confirmation of the individual's eligibility under FMLA.
- ❑ I affirm that the worksite employee listed above is a "key employee" as defined by Title I, Section 104(b) of the FMLA and its implementing regulations (29 CFR 825.217).

Check one:

- ❑ Employee Eligible
- ❑ Employee Ineligible

Date of Eligibility Determination: _____

Employer Notification Form Sent: _____ Date: _____

Medical Certification Recieved: _____ Date: _____

Authorized Signature: _____ Date: _____