



Family and Medical Leave Notification

This form contains medical-related information and must be maintained in files separate from employee personnel files, in locked cabinets with only designated persons having access.

To Be Completed by Employee

Name: _____ Title: _____

Department: _____ Date: _____

I have have not taken a leave of absence in the past twelve months.

I am using: Family and Medical Leave
 Intermittent (partial day) Family /Medical leave

- To care for a child who was born or who was placed for adoption or foster care in my home on: _____
- Because of my own serious health condition (including pregnancy or childbirth related disabilities) that began on: _____ and that renders me unable to perform the essential functions of my job.
- To care for my spouse child parent, who has a serious health condition that began on: _____
- Military Family Leave or Military Caregiver Leave (a covered service member): 12 weeks for my _____ active duty, notification of qualifying exigency or impending call or order to active duty begins on: _____ for 26 weeks to care for my _____ a covered service member who was injured while serving on active military duty or a veteran undergoing medical treatment, recuperation or therapy for serious injury or illness that occurred any time during the five years preceding the date of treatment.

Leave to begin on: _____

I expect to return to work on: _____

My address and telephone number during the leave will be: _____

Date

Employee's Signature