STEWART RICHEY CONSTRUCTION | CONTRACTING GROUP SERVICE GROUP GENERAL CONTRACTING

Family and Medical Leave Request Form

Employee Name: _____

Department: _____

1. I have at least twelve months of service with Stewart Richey Construction (SR) Yes No
2. I have been paid for at least 1,250 hours of work by SR in the past twelve months Yes No

Go forward only if both previous questions were answered YES and you have not used more than twelve weeks of FMLA Leave in the past twelve months.

3. Reason for FMLA Leave:

***Note**: FMLA Leave under the following circumstances must be completed no later than one year after the child's birth, adoption, or foster care placement.*

□ I am the mother or father of a newborn child. The child's birthdate or expected birthdate is _____.
□ I am adopting or have legally adopted a child. The date of the child's placement in my home is/was_____.
□ Placement of a foster child in my home. The date of child's placement in my home is/was _____.
□ Personal request due to exigencies arising out of the fact my spouse, son, daughter, or parent is on active duty or call to active duty status as a member of the National Guard, Reserves, or regular duty Armed Forces personnel who are deployed to a foreign country, in support of a contingency operation.

***Note**: In each case below, a serious health condition is defined as requiring one of the following: (1) inpatient care (i.e. an overnight stay); (2) a period of incapacity of more than three consecutive calendar days, and treatment two or more times by a health care provider, or treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider; (3) incapacity due to pregnancy or prenatal condition; (4) a chronic condition requiring at least two visits per year for treatment by a health care provider; or (5) a permanent/long-term condition requiring supervision – This does not include voluntary or cosmetic treatments unless inpatient hospital care is required.*

***Note**: In each case below, a Certification of Health Care Provider must be completed and returned within 15 calendar days of submission of this form.*

□ Care for my seriously ill mother or father. (if not your biological or adoptive parent, you must present satisfactory evidence of parental relationship – care for a mother-in-law or father-in-law does not qualify for FMLA Leave)
□ Care for my seriously ill spouse. (must be legal spouse; unmarried domestic partners do not qualify for FMLA Leave)
□ Care for my seriously ill child. (if not your biological, adoptive, foster, or step-child, you must present documentation of parent-child relationship)
□ Personal request due to my serious health condition or injury (would include recovery from childbirth or extended pre-natal care).

***Note**: In the case below, a Serious Injury or Illness of Covered Service Member Certification Form must be completed and returned within 15 calendar days of submission of this form.*

□ I am the next of kin of a covered service member who has a serious illness or injury incurred in the line of duty, while on active duty.

4. I understand that FMLA Leave is strictly unpaid leave that is used at the employee's discretion for qualifying events. Accrued paid leave may be used as part of the 12 weeks, under the conditions noted previously, at the employee's discretion.
5. I understand that in cases where FMLA Leave is foreseeable, I must apply, for FMLA Leave a minimum 30 days in advance. In cases where FMLA Leave is not foreseeable, I understand it is my responsibility to apply for FMLA Leave as early as possible and practicable, either before or after the FMLA Leave event.

***Note**: In all circumstances, employees are required to complete this form.*

6. My first day of absence from work will be _____, and I will return to work on _____ _____. If exact dates are unknown, please enter approximate dates.

***Note**: Total absence may not exceed twelve weeks or twenty-six weeks for service member caregiver leave. In cases of childbirth, adoption, or foster child placement, the employer may require the leave to be taken in a single continuous period. In cases of serious health condition, leave may be taken intermittently for medical reasons, according to a schedule approved by the health care provider (attach leave schedule to the Certification of Health Care Provider Form).*

7. I understand that FMLA Leave is strictly unpaid leave. Requests for paid time off will be processed according to company policy. Use of paid time off **may** be counted toward my twelve weeks of FMLA leave.
8. I understand that sick and vacation leave will not accrue and holidays will not be compensated during non-paid absences.
9. I understand that I am responsible for making arrangements for payment of insurance benefits.
10. I understand that if the absence from work is due to a personal health condition, I must submit a 'Return to Work' report from my health care provider prior to returning to work.
11. I understand that if the absence from work is due to a personal health condition, I must successfully submit to a 'Fit for Duty' physical (at the expense of SR) prior to returning to work.
12. I understand that when I return to work, I will be returned to the same job I left or an equivalent job and that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing.

Employee Signature: _____ Date: _____

□ Approved
□ Denied

Authorized Company Signature: _____ Date: _____

If you need help in using this form, please contact the HR Department at 270.842.5184.