Northern Arizona Council of Governments

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CHRIS FETZER
EXECUTIVE DIRECTOR

FAMILY MEDICAL LEAVE REQUEST FORM

INSTRUCTIONS FOR THE EMPLOYEE

- Complete the following form.
- Attach your completed Medical Certification Statement to this form and submit DIRECTLY to NACOG Human Resources, 119 E. Aspen, Flagstaff, AZ 86001. Fax (928) 213-5249

EMPLOYEE INFORMATION	
Employee Name:	
Employee Social Security Number	Position:

TYPE OF LEAVE

I hereby request the following type of Family Medical Leave:

☐ Birth of my son or daughter/Adoption Anticipated date of birth or placement:_____

☐ *Family leave to care for a spouse, son, daughter, or parent with a serious health condition

Family member's full name:_____

Relationship to you: ____Spouse ____ Parent ____Son or daughter—MUST specify age_____
____Other (if applicable)_____

☐ *Medical leave for my own serious health condition

*Indicates the mandatory need for a Medical Certification Statement to be completed.

AMOUNT OF LEAVE

(1) I request that the leave be granted for the following period of time:
Beginning on (date):_____ Ending on (date):_____

(2) I further request that the leave be granted for the following reduced or intermittent leave schedule:
Please attach schedule of intermittent leave.

EMPLOYEE CERTIFICATION AND SIGNATURE

I understand that I am required to use my accrued sick days as part of my leave of absence under the FMLA. After I have exhausted my sick days, I understand that the remainder of the leave period will then consist of vacation leave and/or leave without pay.

I understand that during the period of FMLA Leave, I will remain on the NACOG health plan under the same condition that applied before the leave commenced. To continue health benefits for my dependent coverage, I must continue to make contributions that I made to the plan before taking leave. I understand that if I fail to contribute to my health premiums for dependent coverage, it will result in loss of coverage. If I fail to return to work upon the expiration of FMLA Leave, I may be subject to immediate termination unless an extension is granted. I also understand that if I do not return to work after the expiration of the FMLA Leave, then I will be required to reimburse NACOG for any payment of health insurance premiums paid on my behalf during the unpaid leave portion of the FMLA Leave, unless the presence of a serious health condition prevents me from performing my job or to circumstances beyond my control.

Signature:_____ Date:_____

Print Name:_____