FAMILY AND MEDICAL LEAVE EMPLOYEE REQUEST FORM

EXHIBIT A

Henderson County policy allows for a maximum of 12 weeks of FMLA Leave taken in the preceding twelve – (12) month period, measured backward from the date an employee uses any FMLA leave (rollback period) with the exception of the Military Caregiver Leave which allows an eligible employee to a combined total of 26 work weeks of leave during the preceding twelve (12) month period.

To Be Completed By Employee:

Employee Name:	**Home Telephone Number:**
Current Mailing Address:	
Henderson County Department:	**Supervisor E-Mail:**
Employee Supervisor:	**Supervisor Phone #:**

Reason for Leave:

- ☐ Birth of my child and/or to care for the new born child
- ☐ Placement of a child with me for adoption or foster care
- ☐ Military Qualifying Exigency Leave

THE FOLLOING LEAVE REQUESTS REQUIRE A COMPLETED MEDICAL CERTIFICATION – Contact HRD:

- ☐ My own serious health condition
- ☐ To care for a family member with a serious health condition
- ☐ Military Caregiver Leave

Briefly explain reason for leave request (If leave is to care for a family member, please specify your relationship to the family member):

ANTICIPATED DATES OF LEAVE:

From: _____ (Date) Through: _____. (Date)

I am requesting leave on an intermittent or reduced leave schedule. ☐ Yes ☐ No

I anticipate that I will need the leave on the following schedule or basis:

Henderson County policy requires an employee to exhaust all accrued SICK Leave before using accrued vacation leave or going on leave without pay.

After all of my sick leave is exhausted, I would like to:

- ☐ Exhaust all accrued vacation leave
- ☐ Leave without pay
- ☐ Exhaust a portion of my accrued vacation leave
- ☐ Use _____ vacation hours; or
- ☐ Leave a balance of _____ vacation hours.

I understand that I will be required to furnish medical certification of a serious health condition and/or the need for me to provide care for a family member. I further understand that this certification must be submitted to the Human Resources Department within 15 days. I authorize the Henderson County Human Resources Department to obtain clarifying information from the health care provider regarding my request for family and medical leave.

Employee Signature: **Date:**

If your leave is approved, you will receive a designation notice from Human Resources Department. Medical details of your FMLA leave will not be shared with anybody, including your supervisor, without your permission. HRD will notify your supervisor when your FMLA request is approved or denied. You may contact HRD at 697-4669 with any questions.

Please forward to HRD at hrd@hendersoncountync.org or fax 698-6184

To Be Completed by Human Resources Department:

Date Request Received:	Medical Certification Received:
Employee has worked ☐ at least 12 months for Henderson County. ☐ at least 1,250 hours (1,040 for OSP departments) in the 12-month period immediately preceding the start of the leave	
Employee is ☐ eligible ☐ not eligible for FMLA	Condition ☐ qualifies ☐ does not qualify for FMLA
FMLA ☐ approved ☐ denied	Number of Sick Hours Available: Hours Date: Number of Vacation Hours Available:
Effective date of FMLA:	Signature of HRD Representative: