FMLA EMPLOYEE LEAVE REQUEST FORM

Employee: __________________________ Date: ________

Job Title: __________________________ Supervisor: __________________________

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons, and up to 26 weeks of unpaid, job-protected leave in a single 12-month period to care for a covered family member who was seriously ill or injured during their active military service. Submit this request form to your supervisor at least 30 days before the leave is to commence, when practicable. When submission of the request 30 days in advance is not practicable, submit the request as early as is practicable. In most cases, it should be practicable to provide notice of the need for leave either the same day as the need for leave becomes known, or the next business day. The employer reserves the right to delay or deny leave for failure to give appropriate notice when such delay/denial would be permitted under federal or state law.

ELIGIBILITY

1. Counting any periods of time that you worked for the company (whether they were consecutive or not), have you worked for the company for a total of 12 months of more? (If “yes,” continue to next question. If “no,” stop here.)
   Yes No

2. During the past 12 months, have you worked at least 1,250 hours? (approximately eight months of 40-hour weeks or one year of 25-hour weeks)?
   Yes No

3. Have you previously received medical or family leave?
   Yes No

   If yes, provide information below:

   Dates of leave: From________________ to________________

   Purpose of leave: ____________________________________________

   __________________________________________________________________

4. Have you taken any intermittent leave? Yes No

5. Have you taken time off from scheduled hours? Yes No

   If “yes,” provide details: __________________________________________

   __________________________________________

   __________________________________________

   __________________________________________

REASONS FOR REQUESTING LEAVE:

   Leave must be granted for any of the following reasons:

   ▪ For a serious health condition that makes it unable for you to perform your job
   ▪ To care for your child, spouse, or parent who has a serious health condition
   ▪ To care for your child after birth, or for placement after adoption or foster care
   ▪ For a qualifying exigency arising out of your spouse, son, daughter, or parent’s active duty or notification of an impending call or order to active duty in the armed forces in support of a contingency operation
   ▪ To care for your spouse, son, daughter, parent, or next of kin recovering from a serious injury or illness suffered while on active duty in the armed forces
I am requesting leave for the following reason [check one]:

__ My own serious health condition

__ Serious health condition of:

Spouse
Name: __________________________

Child
Name: __________________________

Parent
Name: __________________________

__ Birth of a child
Expected delivery date is: __________

__ Adoption or placement of a child for foster care
Child's name: __________________________
Scheduled date of adoption or placement: __________________________

__ A qualifying exigency arising out of active duty or notification of an impending call or order to active duty in the armed forces in support of a contingency operation of:

Spouse
Name: __________________________

Son
Name: __________________________

Daughter
Name: __________________________

Parent
Name: __________________________

Next of kin
Name: __________________________

__ Recovery from a serious injury or illness suffered while on active duty in the armed forces of:

Spouse
Name: __________________________

Son
Name: __________________________

Daughter
Name: __________________________

Parent
Name: __________________________

Next of kin
Name: __________________________

I HAVE or HAVE NOT previously taken FMLA-protected leave for this reason [circle one].

DATES OF LEAVE REQUESTED:

I request leave from ________________ to ________________.

I request intermittent leave according to the following schedule: __________________________

______________________________

I request a reduced schedule leave according to the following schedule:

______________________________

The total number of days of leave that I request is _________.

(31500900)
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EMPLOYEE STATEMENT:

I certify that the statements made above are true and accurate. I understand that I have an obligation to respond to any questions from my employer designed to determine whether my absence is potentially FMLA-qualifying. Furthermore, I understand that if I fail to respond to any reasonable inquiry by my employer regarding this leave request, the employer may deny my FMLA leave request if the employer is unable to determine whether the leave is FMLA-qualifying.

Signature: __________________________ Date: ____________

TO BE COMPLETED BY SUPERVISOR

Staff member was hired on ________________________.

He/she started in this department on ____________________.

Staff member is Full time

Part time Regular hours are _______ hrs on ________
days of the week for a total of _______ hours per week.

Schedule commenced on _______ (if there was an earlier
schedule, list below):

Are there 50 or more staff members at or within 75 miles
of the worksite where the staff member works? Yes    No

How will the staff member's duties and responsibilities in your unit be handled
during his or her leave of absence?

Employee has previously requested family or medical leave on ________________.

Leave taken from __________ to __________. Total time taken: ________.

Supervisor: ______________________ Title: ______________________

Date: ______________________ Telephone #: ______________________
FMLA EMPLOYEE STATEMENT OF FAMILY RELATIONSHIP

In support of my request for medical leave dated _____________________ to care for my
(check one):

___ Spouse
___ Child
___ Mother
___ Father
___ Next of kin

(name) __________________________________________

due to his/her serious medical condition, I have attached a copy of the following:

___ Birth certificate
___ Marriage certificate
___ Court document: ________________________________

_or_

I hereby certify that (name) ______________________________
is my (check one):

___ Spouse
___ Child
___ Mother
___ Father
___ Next of kin

I understand that any deliberate misrepresentations made in this statement are punishable
pursuant to the company’s policies regarding misrepresentations by employees. I certify that
all of the statements made herein are true and accurate to the best of my knowledge and belief.

Employee: ______________________________ Date: __________________

Signature: ________________________________________________