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| **LEAVE REQUEST FORM** |

**Please Note: Employees are required to meet the following requirements to be eligible for leave under the Family and Medical Leave Act (FMLA):**

1. An eligible employee is required to have worked for the employer for at least 12 months;

**AND**

1. The employee is required to meet the 1250 hours of service requirement within the 12- months preceding the leave.

Employee's Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home/Cell Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Hire: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Estimated Dates for Requested Leave**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Estimate the beginning and ending dates for the requested leave. For example: 01/03/2016 – 02/03/2016).*

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| **Reason for Leave (Check all that apply):** |

[ ]  Birth of a child and to care for the newly-born child, or placement of a child with the employee for adoption or foster care.

[ ]  Because you are needed to care for your [ ]  spouse; [ ] child; [ ]  parent due to his/her serious health condition.

[ ]  Your own serious health condition.

[ ]  Because of a qualifying exigency arising out of the fact that your [ ]  spouse; [ ]  son or daughter; [ ]  parent is on covered active duty or call to covered active duty status with the Armed Forces.

[ ]  Because you are the [ ]  spouse; [ ]  son or daughter; [ ]  parent; [ ]  next of kin of a covered service member with a serious injury or illness.

[ ]  Other reason: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Type of Leave Requested (Check all that apply):** |

[ ]  Accrued paid vacation or paid-time off [ ]  Unpaid Family and Medical leave

[ ]  Accrued paid medical/sick leave [ ]  Other type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To receive paid leave during all or part of an FMLA leave, employees must satisfy the paid leave policy requirements.

Is intermittent leave or reduced work schedule requested? If yes, explain why it is needed and the leave schedule proposed:

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| **Intention To Return To Work When The Leave Ends (select one):** |

[ ]  Employee **will not** be returning to work.

 [ ]  Employee intends to return to work.

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| **Authorization, Certification, and Signature** |

Who provided information to complete the form (if other than employee)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person who completed form: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I certify that the above information is true and correct to the best of my knowledge. I understand that any misrepresentation concerning the above facts may result in termination of employment.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Employee's Signature Date