Request for Family and Medical Leave
Family and Medical Leave Act

Employee Information:

Name: _____ Date: _____

Position: _____ Department: _____

Date of Hire: _____ Start Date of Leave: _____ Date of Return: _____

Reason for leave (check the reason that applies below):

- ☐ Birth of Child ☐ Adoption of Child
- ☐ Care for parent, child or spouse with a serious health condition
- ☐ My own serious health condition that prohibits me from performing the essential functions of my position
- ☐ Care for spouse, child or parent who is a covered military member on "active duty"
- ☐ Care for spouse, child, parent, or next of kin who is a service member with a serious injury or illness

Have you taken a leave of absence under this policy during the preceding 12 months? ☐ Yes ☐ No

If yes, how many workweeks (or portions thereof) have you taken? _____

Are you requesting intermittent leave or a reduced schedule? ☐ Yes ☐ No

Acknowledgement:

I understand that I need to provide medical certification of my own serious health condition or that of my parent, child or spouse. I also understand that medical certification forms are available from Human Resources.

- ☐ Medical certification is attached.
- ☐ Medical certification will be provided to Human Resources within fifteen (15) days.

I understand that Human Resources will evaluate my request for a family/medical leave and notify me whether my request has been approved or denied. I understand that Human Resources may need additional information to evaluate my request for FMLA leave and I agree to provide that information within the requested time period.

I understand that my FMLA leave will run concurrently with all other available leave, paid or unpaid, including, but not limited to, worker's compensation leave; sick, vacation or personal leave; leave as a reasonable accommodation for a qualified individual with a disability; or any other paid time off used for qualifying FMLA leave reasons. Also, I understand that this leave will be counted against my annual family medical leave entitlement.

I understand that if I have accrued paid leave available and I am granted this FMLA leave, I will be required to use all but five (5) vacation and five (5) sick days of my accrued paid time off during the FMLA leave. Also, I may request to use the remaining ten (10) days of paid accrued time and understand that any FMLA leave that extends beyond any time covered by accrued paid leave will be designated as unpaid FMLA leave. I understand that even if my request for leave does not comply with the City's rules for allowing paid* time off, I remain entitled to take unpaid FMLA leave. I

understand that I will not accrue any vacation or sick leave unless I work or get paid for at least 14 days in any given month.

I have read the City's Family and Medical Leave policy, and I agree to abide by its requirements. My signature affirms that I have been truthful in my request for FMLA leave. I understand that falsification of information may lead to disciplinary action, up to and including possible termination.

I understand that 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.

* For example, if I am requesting leave to care for a qualifying family member with a serious health condition, but my only accrued paid leave is sick leave.

EMPLOYEE'S SIGNATURE: _____

Approval:

HUMAN RESOURCES: _____ Date: _____