

EMPLOYEE INFORMATION:

Employee Name (First, Middle Initial, Last):

Home Address:	City:	State:	Zip:
Job Title/ Department:	Telephone Number:	Personal Email:	

ABSENCE INFORMATION

<input type="checkbox"/> This is a new request.	<input type="checkbox"/> Employee will be hospitalized.	<input type="checkbox"/> This is an update to an existing request.
Requested Start Date of Leave:	Anticipated Return Date:	

TYPE OF LEAVE:

<input type="checkbox"/> Consecutive Leave of Absence	<input type="checkbox"/> Intermittent Absence (information required below)
Describe your intermittent or reduced work schedule (e.g., "up to 2-3 sick days a month per doctor"). This must be medically necessary and documented in a current medical certification form from your health care provider.	

LEAVE TYPE:

Pregnancy/childbirth leave*

Your own serious health condition that makes you unable to perform some or all of the essential functions of your job* (not work related, work related leave information requires Workers' Compensation paperwork, please see HR)

A serious health condition affecting your spouse; child; parent for which you are needed to provide care *

*For leaves due to your own or a family member's serious health condition, completion of a Certification of Health Care Provider form is required within 15 days of request.

Bonding Leave - for birth/placement/adoption of child - actual or estimated date of birth/placement

USERRA Military Leave

Qualifying Exigency Leave arising out of the fact that your spouse, child or parent is on covered active duty or call to covered active duty

Military Caregiver Leave to care for a spouse, child, parent, or next of kin who is a covered service member with a serious injury or illness

ACKNOWLEDGEMENTS:

- I understand a Medical Certification Form will be required for any leave due to a serious health condition.
- I understand my request for leave may be denied.
- I understand all requests for personal leave must be approved in advance by supervisor and Human Resources
- I understand it is my responsibility to notify my manager, Human Resources, and isolved FMLA Services (for FMLA leave) as/if my circumstances change.
- If my request for leave is granted, I understand that my benefits will continue during my FMLA leave and that I will work with the company to pre-arrange to pay my share of applicable premiums that will accrue during my leave. If I do not return to work following leave, I understand that I may be required to reimburse my employer for its share of health insurance premiums paid on my behalf during my leave.

Employee Signature:

Date:

TO BE COMPLETED BY EMPLOYER:

Number of Hours Worked in the 12-month period prior to the date signed	Hire Date (or Service Date if different)	
Employee ID	*Provide Number of FMLA Hours Taken (if Employee is within 12 months of having used FMLA)	Work Location

Indicate Employee's Normally Scheduled Work Hours per Day

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
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