Clarinda Regional Health Center

FMLA REQUEST FORM

REVIEWED 2/2025

EMPLOYEE INFORMATION:

Employee Name (First, Middle Initial, Last):

Home Address: | City: | State: | Zip:

Job Title/ Department: | Telephone Number: | Personal Email:

ABSENCE INFORMATION

☐ This is a new request. ☐ Employee will be hospitalized. ☐ This is an update to an existing request.

Requested Start Date of Leave: | Anticipated Return Date:

TYPE OF LEAVE:

☐ Consecutive Leave of Absence ☐ 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

isolved