Family and Medical Leave Request Form

Employee Name _____ Employee ID _____

Work Location _____

I request to use family and medical leave from _____ to _____

Please check one.

- ☐ For incapacity related to pregnancy and childbirth.
- ☐ To care for my child after birth, or placement for adoption of foster care
- ☐ To care for my *(circle one)* spouse, son or daughter, or parent, who has a serious health condition
- ☐ For my own serious health condition which makes me unable to perform my job
- ☐ To care for my *(circle one)* spouse, son or daughter, parent, or next of kin who has received a serious illness or injury in the line of duty while on active duty.
- ☐ To attend to a qualifying exigency arising from the fact my (*circle one)* spouse, son or daughter, or parent has been called to active duty status in support of a contingency operation.

**The FMLA requires 30-days advance notice to the Employer prior to the effective date of the leave period. My request fails to comply with the required advance notice requirement for this reason:

_____

_____

I understand that FMLA is, by default, leave without pay. I request to use available paid leave during the period of absence as follows:

_____ Hours of Sick Leave _____ Hours of Compensatory Time
_____ Hours of Personal Leave _____ Hours of Annual Leave

I request to charge _____hours to leave without pay during the period of absence.

I understand that use of Family and Medical Leave for any combination of circumstances listed above will be limited to a total of 12 work weeks in a rolling 12-month period.

_____ _____
Signature of Employee Date

Does your spouse work for State government? ☐ Yes ☐ No

Which Agency: _____
Name of Spouse _____

The original of this form and appropriate supporting documents should be submitted to the appropriate Appointing Authority/designee. Please retain copies of all information for your records.

Record Retention: Upon, completion, this form shall be retained permanently in the official and local medical file of the employee.