REQUEST FOR FAMILY OR MEDICAL LEAVE OF ABSENCE

Employee Information		
Employee Name		Date
Address		Telephone
		Social Security
Type of Leave Requested ☐ 12 weeks ☐ Extension (no guarantee of reinstatement)	Employment Status ☐Full-time ☐ Part-time	Time Period Requested From To
Reason for Requested Leave/Extension (employee need not provide specific health issue)		
If leave is to be taken to care for a family member, please complete the following section:		
Name of family member and relationship to you. Describe care you will provide to your family member and estimate leave needed to provide care:		
If leave is to be taken on an intermittent/reduced leave basis, please complete the following section:		
Reason leave must be on a reduced or intermittent basis. List dates of leave and corresponding hours to be taken.		

If you are taking leave for your own serious health condition or to care for a family member with a serious health condition, you must provide a Department of Labor Certification Form.

_____ _____

Employee's Signature Date Supervisor's Signature Date

Approval/Denial

The above stated employee has completed a minimum of 12 months of employment and worked at least 1250 hours and taken no more than 12 work weeks of FMLA leave in the 12 months preceding the requested leave.
☐ Yes ☐ No

This employee's request for leave of leave is:

[ ] Granted

[ ] Denied Reason: _____

_____ _____

Human Resources Date