FAMILY OR MEDICAL LEAVE REQUEST FORM

INSTRUCTIONS FOR THE EMPLOYEE:

- *Complete your part of the form and submit it to HR.*
- *You will be notified as to whether the leave is approved or not.*

EMPLOYEE INFORMATION

Employee Name		Employee Number
Job Title	Department	Location

TYPE OF LEAVE

I hereby request the following type of leave:

☐ Family leave for the:

- ☐ Birth of my son or daughter
- ☐ Placement of a child with me for ☐ adoption ☐ foster care

Anticipated date of birth or placement: _____

☐ Family leave to care for a spouse, son, daughter or parent with a serious health condition

Family member's full name: _____

Relationship to you: ☐ spouse ☐ parent ☐ son or daughter ☐ other (if applicable)

☐ Medical leave for my own serious health condition (specify): _____

_____

☐ Servicemember Care

☐ Exigency Leave

AMOUNT OF LEAVE

(1) I request that the leave be granted for the following period of time:

Beginning on (date): _____ Ending on (date): _____

(2) I further request that the leave be granted for the following reduced or intermittent leave schedule:

_____

(3) I would like to substitute the following paid leave time, if applicable, during my family or medical leave:

Type: _____ Amount: _____

EMPLOYEE CERTIFICATION AND SIGNATURE

I hereby certify that the information given above is true and correct to the best of my knowledge. I understand that misrepresentation or omission of the reason for leave or any of the facts supporting the need for leave may result in denial of the leave and will subject me to discipline up to and including termination.

Signature: _____ Date: _____

MAINTAIN THIS FORM IN A FMLA CONFIDENTIAL FILE

HR USE ONLY

Received By:	
Signature	Date

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