



REQUEST FOR FAMILY & MEDICAL LEAVE

Section 1: PERSONAL INFORMATION (Employee completes Sections 1 and 2 and returns completed form to Supervisor/Manager)		
Last Name:	First Name:	Employee No.
Home Address:	Phone (Work):	Department:
Date Submitted:	Phone (Home):	Job Title:
Signature:	E-Mail:	Hire Date:

Please review the following statement. For any questions call Employee Health at 793-8005.

If circumstances of your leave change and you're unable to return to work on expected date you will be required to provide EH and your department director/supervisor a status update as soon as you are made aware of the change. If this FMLA is for your illness, you will be required to provide EH with a work status with or without restrictions from your Healthcare Provider before being restored to employment and scheduled to work. If you agree to the terms and conditions listed above please sign:

Signature

Section 2: EMPLOYEE: Check the type of leave, supply the required information in writing, and provide attachments as indicated.

Family and Medical Leaves (required medical certifications must be returned within 15 days of the date on this form)

<input type="checkbox"/>	Employee Illness	Certificate of Health Care Provider (Form 1002-E)
<input type="checkbox"/>	Child/Parent/Spouse Illness	Certificate of Health Care Provider for Family Member's Illness/Injury (Form 1002-f)
<input type="checkbox"/>	Maternity	Certificate of Health Care Provider (Form 1002-E)
<input type="checkbox"/>	Paternity	Certificate of Health Care Provider (Form 1002-f) (Must be taken within one year of birth)
<input type="checkbox"/>	Adoption/Placement of Foster Child	Letter of Placement (Must be taken within one year of Placement)
<input type="checkbox"/>	Military Caregiver	Certification for Serious Illness or Injury of Covered Service Member (DOL WH-385-V)
<input type="checkbox"/>	Military Exigency	Certification of Qualifying Exigency (DOL WH-384)

Personal Leaves - See Human Resources

I request that my leave begin on _____ and end on _____. (If necessary, give approximate dates.)

Section 3: SUPERVISOR/MANAGER/DEPARTMENT: Complete this section.

Name (Print):	Email:
Signature:	Phone:
Date:	
Names(s) of any others to receive communication (Timekeeper/Manager/Supervisor):	
Time Keeper Notified: <input type="checkbox"/> YES <input type="checkbox"/> NO Hours Worked in the Past 12 Months (Minimum 1250 worked): _____	

Section 4: ELIGIBILITY – EMPLOYEE HEALTH & WELLNESS REPRESENTATIVE: Complete this section.

Has Employee had absences counted towards FMLA entitlement in the past 12 months? NO YES

If yes, indicate dates/hours used: From _____ to _____

FMLA Benefit Hours Utilized to date: _____ FMLA Benefit Hours Remaining: _____ ELIGIBLE NOT ELIGIBLE

If NOT eligible, list reason:

Signature, Employee Health & Wellness Representative

Date

**Certification of Qualifying Exigency
For Military Family Leave
(Family and Medical Leave Act)**

U.S. Department of Labor
Wage and Hour Division



OMB Control Number: 1235-0003
Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.309.

Employer name: _____

Contact Information: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as “unknown,” or “indeterminate” may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 CFR 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: _____
First
Middle
Last

Name of military member on covered active duty or call to covered active duty status:

First
Middle
Last

Relationship of military member to you: _____

Period of military member’s covered active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member’s covered active duty or call to covered active duty status. Please check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status.

- A copy of the military member’s covered active duty orders is attached.
- Other documentation from the military certifying that the military member is on covered active duty (or has been notified of an impending call to covered active duty) is attached.
- I have previously provided my employer with sufficient written documentation confirming the military member’s covered active duty or call to covered active duty status.

PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.

Yes No None Available

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____

Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?

Yes No

If so, estimate the beginning and ending dates for the period of absence:

3. Will you need to be absent from work periodically to address this qualifying exigency? Yes No

Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours _____ day(s) per event.

PART C:

If leave is requested to meet with a third party (such as to arrange for childcare or parental care, to attend counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

Email: _____

Describe nature of meeting: _____

PART D:

I certify that the information I provided above is true and correct.

Signature of Employee _____ Date _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**