



Request For Family and Medical Leave

This Form for SAMC Internal Use ONLY

Section 1: PERSONAL INFORMATION (Employee completes Sections 1 and 2 and returns completed form to Supervisor/Manager)		
Last Name:	First Name:	Employee #/FTE Status:
Home Address:	Phone (Work):	Department:
Date Submitted:	Phone (Home):	Job Title:
Signature:	E-Mail:	Hire Date:
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):		
Timekeeper 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 <input type="checkbox"/> YES <input type="checkbox"/>		
If yes, indicate dates/hours used: From _____ to _____		
FMLA Benefit Hours Utilized to date: _____ FMLA Benefit Hours Remaining: _____ <input type="checkbox"/> ELIGIBLE <input type="checkbox"/> NOT ELIGIBLE		
If NOT eligible, list reason:		
Signature, Employee Health & Wellness Representative		Date

-DO NOT REMOVE FROM CERTIFICATION PACKET-