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)

☐	Employee Illness	Certificate of Health Care Provider (Form 1002-E)
☐	Child/Parent/Spouse Illness	Certificate of Health Care Provider for Family Member's Illness/Injury (Form 1002-f)
☐	Maternity	Certificate of Health Care Provider (Form 1002-E)
☐	Paternity	Certificate of Health Care Provider (Form 1002-f) (Must be taken within one year of birth)
☐	Adoption/Placement of Foster Child	Letter of Placement (Must be taken within one year of Placement)
☐	Military Caregiver	Certification for Serious Illness or Injury of Covered Service Member (DOL WH-385-V)
☐	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: ☐ YES ☐ 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