APPLICATION FOR FAMILY AND MEDICAL LEAVE

(Family and Medical Leave Act of 1993)

Employee Information

Name:____ Department:_________________________________

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Reason for FMLA Request	Type of FMLA Request
‰ %RQG ZLWK 1HZERUQ &KLOG RU $GRSWLRQ)RVWHU &DUH ‰ Serious Health Condition including Maternity 3DW*HUQLW ‰ Employee ‰ (PSOR\HH¶V 6SRXVH ‰ (PSOR\HH¶V 3DUHQW ‰ (PSOR\HH¶V &KLOG ‰ A completed Certification of Physician or Practitioner is Required	Check One: ‰ Continuous Leave ‰ Reduced Work Schedule* ‰ Intermittent* *Not available for Maternity, Paternity, Adoption or Foster Care Placement *Available if Health Care Provider Certifies Medical Necessity

Begin Date of Requested Leave: ______/_____/_____ End Date of Requested Leave, if known: ______/_____/_____

NOTE: $ OHDYH UHTXHVW EDVHG RQ DQ HPSOR\HH¶V VHULRXV K HPSOR\HH¶V VSRXVH parent must FKLOG be accompanied by verifying medical certification from a physician. (Certification of Physician or Practitioner Form)

Additional Information:____

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____ Date: ______/_____/_____

Supervisor Acknowledgment

I have reviewed this Request and discussed the proposed leave with the employee. My signature confirms my knowledge RI WKH HPSOR\HH¶V UHTXHVW IRU OHDYH

Supervisor Signature: Date: /

-6925

FOR HR USE ONLY:
Eligibility
Confirmed by:

____
Human Resources Representative