Family and Medical Leave Request Form

Date: ________
Employee Name:__________________________ SSN #: _____________________________
Job Title: ________________________________ Supervisor: ____________________________

Under the Family and Medical Leave Act eligible employees are entitled to up to twelve weeks of unpaid, job-protected leave for certain family and medical reasons. When possible, submit this request form to your supervisor at least 30 day before the leave is to commence. When submission 30 days in advance is impossible due to unavoidable circumstances, submit the request as early as is possible. When permitted under state or federal law, employer may deny or postpone leave for failure to give appropriate notice.

ELIGIBILITY

1. Counting any periods of time that you worked for the company (whether they were consecutive or not) have you worked for the company for a total of 12 months of more?

   ☐ YES ☐ NO

   (If "yes," continue to next question. If "no," stop here.)

2. During the past 12 months, have you worked at least 1,250 hours? (approximately eight months of 40-hour weeks or one year of 25-hour weeks)?

   ☐ YES ☐ NO

   (If "yes," continue to next question. If "no," stop here.)

3. Have you previously received medical or family leave? If yes, provide information below:

   Dates of leave: From __________________________ To __________________________

4. Purpose of Leave: ____

5. Have you taken any intermittent leave?

   ☐ YES ☐ NO

6. Have you taken time off from scheduled hours?

   ☐ YES ☐ NO

If “yes” provide details: ____

REASONS FOR REQUESTING LEAVE:

I am requesting leave for the following reason (Circle one):

☐ **Personal serious health condition**

☐ **Serious health condition of:**

Spouse Name: ____

Child Name: ____

Parent Name: ____

☐ **Birth of a child**

Expected delivery date is: ___________________________________

☐ **Adoption or placement of a child for foster care**

Child's name: ____

Scheduled date of adoption or placement: ________________________

DATES OF LEAVE REQUESTED:

I request leave from ______________________ to ______________________

I request intermittent leave according to the following schedule:

____

____

I request a reduced schedule leave according to the following schedule:

____

____

The total number of days of leave requested ______________________.

EMPLOYEE STATEMENT:

I agree to return to work on ______________________. If circumstances change, I agree to inform my supervisor by submitting a NOTICE OF CHANGES IN APPROVED MEDICAL OR FAMILY LEAVE form. I understand that my benefits will continue during my leave and that I will arrange to pay my share of applicable premiums.

Signature:____

Date: _________

TO BE COMPLETED BY SUPERVISOR

Staff member was hired on _____________________

He/she started in this department on _____________________
Staff member is:

☐ FULL-TIME ☐ PART-TIME

Regular hours are _____ hrs on _____ days of the week for a total of _____ hours per week.

Schedule commenced on __________
Are there 50 or more employees within 75 miles of the facility where employee works?

☐YES ☐NO

Has the workforce been this large for at least 12 months?

☐YES ☐NO

How will the staff member's duties and responsibilities in your unit be handled during his/her leave of absence? ____
____

Employee has previously requested family or medical leave on _________________

Leave taken from _________ to _________ Total time taken _________

Supervisor: ___________________________________ Title: ______________________

Date: __________________________ Telephone #: __________________________

TO BE COMPLETED BY HUMAN RESOURCES

Prior leave requests confirmed: __________________________________

Leave is:

☐ APPROVED

☐ DENIED for the following reason(s):

____

____

Request approved /denied by: ____

Date: __________