REQUEST FOR FAMILY/MEDICAL LEAVE

Employee Name_____ Date of Request_____

Department_____ Position Title_____

Hire Date_____

I request a Family/Medical Leave for the following reason (check one):

_____ **A.** The birth of a child and/or in order to care for such child.

_____ **B.** The placement of a child for adoption or foster care.

_____ **C.** In order to care for an immediate family member because such family member has a serious health condition.

Check one: ❑ CHILD ❑ SPOUSE ❑ PARENT ❑ DOMESTIC PARTNER
(Must submit "Medical Certification" within 15 days.)

_____ **D.** Care for an adult child who is incapable of self care. (A child is "incapable of self care" if he/she requires active assistance or supervision to provide daily self care in three or more of the activities of daily living or instrumental activities of daily living, such as caring for grooming and hygiene, bathing, dressing and eating, cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, etc.)

_____ **E.** Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. (Must submit "Medical Certification" within 15 days.)

_____ **F.** To assist a son, daughter, spouse, or parent who is a member of the Armed Forces, including the National Guard or Reserves with a "qualifying exigency" related to covered active duty or a call to active duty status.

Check one: ❑ SON ❑ DAUGHTER ❑ SPOUSE ❑ PARENT
(Must submit "Medical Certification" of Qualifying Exigency)

_____ **G.** To care for a son or daughter, spouse, parent or "next of kin" covered servicemember with a serious injury or illness

Check one: ❑ SON ❑ DAUGHTER ❑ SPOUSE
❑ PARENT ❑ NEXT OF KIN
(Must submit "Medical Certification" from Department of Defense or Department of Veteran Affairs within 15 days.)

Method of Leave Requested

_____ **A.** Consecutive Leave

_____ **B.** Intermittent or Reduced Leave Schedule (Specify schedule below)

_____

Date leave is to begin: _____ Expected duration of leave: _____

If the duration of my family/medical leave (total of paid and unpaid time) does not exceed 12 weeks (or 26 weeks to care for an injured servicemember), I will be returned to my same or equivalent position. I understand that if my family/medical leave should exceed 12 weeks (or 26 weeks to care for an injured servicemember), I will be returned to my same or equivalent position, only if available. If my same or equivalent position is not available, I understand that I may be terminated.

Date_____

Employee's Signature_____