

Family and Medical Leave Act (FMLA) Request Form

Instructions: Complete this form to request a leave of absence under the Family and Medical Leave Act (FMLA). After completing, print the form, sign it, and submit it to the Human Resources Department at least 30 days before your leave is scheduled to begin, or as soon as practicable.

1. Employee Information

Employee Full Name:

Employee ID:

Job Title:

Department:

Supervisor Name:

Phone Number:

Email Address:

2. Request Details

Requested Start Date of Leave:

Expected Date of Return to Work:

Type of Leave Schedule (Continuous or Intermittent):

3. Reason for Requesting Leave

Please specify the reason for the FMLA leave request (Type "Yes" next to the applicable reason):

The birth of a child, or placement of a child with you for adoption or foster care:

To care for your spouse, child, or parent who has a serious health condition:

A serious health condition that makes you unable to perform your essential job functions:

A qualifying exigency arising out of the fact that your spouse, child, or parent is a military member on covered active duty:

To care for a covered servicemember with a serious injury or illness (you are the spouse, child, parent, or next of kin):

4. Acknowledgment and Signature

I request leave under FMLA for the reason(s) stated above. I understand that I may be required to provide medical certification supporting this request within 15 calendar days of receiving the request from HR.

Employee Signature (Print and Sign):

Date Signed:

5. HR Department Use Only

Date Request Received:

Employee Eligible for FMLA? (Yes / No):

HR Representative Name:

HR Representative Signature:

Date: