FMLA Request For Leave

Under the Family and Medical Leave Act (FMLA) eligible employees are entitled to take up to 12, or in certain instances 26, weeks of job-protected leave for their own or an immediate family member's significant health need. Please submit this completed and signed request form to the Office of Human Resources 30 days before the leave is to begin, or as soon as possible if less than 30 days' notice is known. Your eligibility under FMLA will be determined and you will be notified. For those meeting eligibility, additional FMLA forms will be emailed to you as soon as administratively possible.

See additional information on the HR FMLA webpage.

Employee Information

Employee Last Name	Employee First Name	Employee Job Title
Employee Department	**Supervisor's Name**	**Today's Date**

Duration of Leave

Leave expected to begin:_____ Leave expected to end: _____

If intermittent or reduced-leave schedule is being requested, please explain why it is needed and the proposed leave schedule.

_____

_____

_____

Reason for Leave

I am requesting leave for the following reason:	
☐	My own serious health condition
☐	Birth of my child; care for my newborn (both parents are eligible)
☐	Placement of child with me for Adoption or Foster Care
☐	To care for child/spouse/parent with a serious health condition Family member's name _____ Family member's relationship: _____
☐	Qualifying exigency because a family member is on or has been called to covered active duty in the Regular Armed Forces (including the National Guard and Reserves) to a foreign country

Employee Signature: _____ Date: _____

Received By: _____ Date Received: _____