Family Medical Leave Request Form (FMLA)

(The following request is to be completed and returned to the Human Resources Office)

____
Employee's Name

____
Employee Number

____
Employee's Department

____
Date

Is your reason for requesting leave due to an injury?	☐ Yes		☐ No
If yes: Did the injury occur at work?	☐ Yes		☐ No
Did the injury occur away from work?	☐ Yes		☐ No
What was the date of injury?	____________________		
Is there ligitation pending?	☐ Yes		☐ No
Was the onset of the injury:	☐ N/A	☐ Gradual	☐ Sudden

What is your leave request for: ☐ Continuous FMLA ☐ Intermittent FMLA

What date does your leave begin: ____________________

What is expected date for your leave to end: ____________________

Which of the following reason is your request for leave:

- ☐ for incapacity due to pregnancy, prenatal medical care or child birth;
- ☐ to care for the employee's child after birth, or placement for adoption or foster care;
- ☐ to care for the employee's spouse, son or daughter, or parent, who has a serious health condition
- ☐ for a serious health condition that makes the employee unable to perform the employee's job
- ☐ Intermittent for a serious health condition that makes the employee unable to perform at a full work schedule
- ☐ Intermittent to care for the employee's spouse, son or daughter, or parent, who has a serious health condition

I can be reached at the following address and phone number during my leave:

____

______________________ ______________________ ______________________
Employee's Signature Date Manager's Signature