

# Request for Family or Medical Leave

PLEASE PRINT

Request for Family or Medical Leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin.

Name \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Department \_\_\_\_\_ Title \_\_\_\_\_

Status:  Full Time  Part Time  Temporary Employee Payroll No. \_\_\_\_\_

Hire Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Length of Service \_\_\_\_\_

I request family or medical leave for one or more of the following reasons:

Because of the birth of my child and in order to care for him or her.

Expected date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Actual date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Leave to start \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expected return date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Because of the placement of a child with me for adoption or foster care. Date of placement \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Leave to start \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expected return date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

In order to care for my spouse, child or parent, who has a serious health condition.\*

Leave to start \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expected return date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

For a serious health condition that makes me unable to perform my job.\* Describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Leave to start \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expected return date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\* A physician's certification may be required for leave due to a serious health condition.

For other reasons. Describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Leave to start \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expected return date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Requested intermittent leave schedule (if applicable: subject to employer's approval) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you taken a family or medical leave in the past 12 months?  Yes  No

If yes, how many workdays? \_\_\_\_\_

I understand and agree to the following provisions:

I have worked for my employer at least one year and at least 1,250 hours in the previous 12 months.

If I fail to return to work after the leave for reasons other than the continuation, recurrence or onset of a serious health condition that would entitle me to Medical Leave or other circumstances beyond my control, and if my employer requires it, I will be financially responsible for the medical insurance premiums the company paid while I was on leave.

This leave will be unpaid, unless it is company policy to be paid; or in the case of my own disability, payment will occur under a company disability insurance plan, if I am so covered.

I may be required to exhaust my paid vacation, personal or sick leave as part on my 12 weeks of leave.

After 12 weeks of leave, if I do not return to work or contact my supervisor or manager on the date intended, it will be considered that I abandoned my job.

Employee Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_

### Leave Approval

For full day leave:

Manager/Supervisors Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

For intermittent or reduced day leave:

Manager/Supervisors Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Human Resources Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Notes \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

### Payroll Instructions

With pay from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Without pay from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Physician Certification For Family or Medical Leave



PLEASE PRINT

NAME \_\_\_\_\_

TITLE \_\_\_\_\_

DEPARTMENT \_\_\_\_\_

Employee Payroll No. \_\_\_\_\_

Status

FULL TIME

PART TIME

TEMPORARY

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## TO BE COMPLETED BY HUMAN RESOURCES

The above named Employee is requesting family and medical leave from work with his/her employer \_\_\_\_\_

**NAME OF EMPLOYER**

It is our understanding that you are currently treating \_\_\_\_\_

**NAME OF INDIVIDUAL**

The Patient is:  The Employee  Spouse of the Employee  Parent of the Employee  Child of the Employee

The Employee is requesting full day leave from \_\_\_\_\_ until \_\_\_\_\_

The Employee is requesting leave on an intermittent or reduced schedule on the following dates: \_\_\_\_\_

Job description (if applicable) is attached.

## To be completed by Physician

Please assist us by clarifying the facts about the requested leave by completing the information below.

1. As a duly authorized medical care provider. I certify that I am currently treating \_\_\_\_\_

**NAME OF PATIENT**

2. The Patient has been diagnosed and is receiving treatment for the following condition: \_\_\_\_\_

3. The relevant medical facts regarding the Patient's condition include the following: \_\_\_\_\_

4. The condition began on \_\_\_\_\_

5. In my opinion, that condition will last until (provide date if possible) \_\_\_\_\_

6. As a result of that condition, it is my opinion that:

The Employee is currently unable to perform his/her employment functions set forth on the attached job description.

The Employee is currently needed to care for the Patient.

Intermittent leave is medically necessary for the Employee or to care for the Patient.

In my opinion, the Employee will not be able to return to work until (provide date if possible) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

If the Patient requires treatment of the medical condition that necessitates intermittent leave, please describe the treatments to be administered: \_\_\_\_\_

The dates of these treatments will be \_\_\_\_\_

In my opinion, the treatments will last until \_\_\_\_\_

As a result of the Patient's condition and/or necessary treatments. It is my opinion that the Employee will be unable to perform his/her employment functions, or is needed to care for the Patient and therefore unable to work during the following intermittent period.

From \_\_\_\_/\_\_\_\_/\_\_\_\_      Until \_\_\_\_/\_\_\_\_/\_\_\_\_      From \_\_\_\_/\_\_\_\_/\_\_\_\_      Until \_\_\_\_/\_\_\_\_/\_\_\_\_

From \_\_\_\_/\_\_\_\_/\_\_\_\_      Until \_\_\_\_/\_\_\_\_/\_\_\_\_      From \_\_\_\_/\_\_\_\_/\_\_\_\_      Until \_\_\_\_/\_\_\_\_/\_\_\_\_

From \_\_\_\_/\_\_\_\_/\_\_\_\_      Until \_\_\_\_/\_\_\_\_/\_\_\_\_      From \_\_\_\_/\_\_\_\_/\_\_\_\_      Until \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
**Physician's Signature**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Physician's Printed Name**

Office mailing address \_\_\_\_\_

\_\_\_\_\_  
Phone No. (\_\_\_\_) \_\_\_\_\_

Physician's Comments: \_\_\_\_\_