**APPLICATION FOR FAMILY MEDICAL LEAVE ACT (FMLA)**

INSTRUCTIONS: This application should be completed by the employee and returned to Human Resources (not to your supervisor).

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start Date of Leave:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expected Return to Work Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this a request for intermittent leave or a reduced work schedule? Yes \_\_\_\_ No\_\_\_\_

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Attach additional information, if applicable.)

**REASON FOR LEAVE:**

* the birth of a child and to care for the newborn child within one year of birth;
* the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
* to care for the employee’s spouse, child, or parent who has a serious health condition;
* a serious health condition that makes the employee unable to perform the essential functions of his or her job;
* any qualifying exigency arising out of the fact that the employee’s spouse, son, daughter, or parent is a covered military member on “covered active duty;” **or**
* Twenty-six workweeks of leave during a single 12-month period to care for a covered servicemember with a serious injury or illness if the eligible employee is the servicemember’s spouse, son, daughter, parent, or next of kin (military caregiver leave).

If the leave is requested based on a serious health condition (either of the employee or the employee’s spouse, parent or child), the health care provider must complete a Certification of Health Care Provider Form. (See FMLA Form Packet.) This certification form must be submitted to Human Resources prior to the start of the leave unless the serious health condition prevents you from doing so, in which case the form must be provided to Human Resources as soon as possible after the leave starts and no later than 15 days from today’s date. Failure to provide a completed certification within 15 days will result in delay or denial of FMLA leave. If you were unable to submit your medical certification prior to beginning your leave, your leave will be conditionally designated as FMLA and that designation will be confirmed or revoked based on the certification provided.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Human Resources Use Only:*

Date Application Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Received By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Certification of Health Care Provider (if needed) provided to Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Based on Application, Leave is:

Approved: \_\_\_\_\_\_\_\_\_\_\_\_ Conditionally Designated Pending Certification: \_\_\_\_\_\_\_\_\_\_ Denied: \_\_\_\_\_\_\_\_\_\_\_\_

If Denied, Give Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Employee Notified of Approval/Conditional Designation/Disapproval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_