

# ***EMPLOYEE FMLA REQUEST FORM***

## **TO BE COMPLETED BY EMPLOYEE:**

Name: \_\_\_\_\_

Division/Department: \_\_\_\_\_

Job Classification: \_\_\_\_\_

Home/Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
(Required)

Home Mailing Address: \_\_\_\_\_  
(City, State, Zip Required)

Date Of Birth/Adoption (If Applicable): \_\_\_\_\_

If For A Family Member, State Their Name And Your Relationship To Them:

\_\_\_\_\_

The Basis For The FMLA Request Is:

- Birth of child, and/or care of newborn, adopted or foster care child
- Care of a qualifying family member with Serious Health Condition
- Employee's own Serious Health Condition
- Military-Related Leave

**The attached documentation supporting this request is a Certification from:**

- Health Care Provider
- Adoption/Foster
- Military

I seek \_\_\_\_\_ hours, days or weeks (circle one)

\_\_\_\_\_ In a block of time or \_\_\_\_\_ intermittently, and

- Please use:
- Sick time first, then vacation, then unpaid leave
  - Vacation first, then sick time, then unpaid leave
  - Unpaid leave
  - Other \_\_\_\_\_

## **TO BE COMPLETED BY DIVISION:**

\_\_\_\_\_

Payroll Clerk

\_\_\_\_\_

Date Received

\_\_\_\_\_

Date Sent to HR

- Employee has worked for the 12 prior months
- Employee has met the 1,250-hours-worked requirement
- Employee has not used up his or her yearly FMLA leave entitlement

Other comments, if any: \_\_\_\_\_

\_\_\_\_\_