Employee FMLA Leave Request

(Family and Medical Leave Request Form)

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to take up to 12 or 26 weeks of job-protected leave for certain family and medical reasons. Submit this request form to your human resource manager at least 30 days before the leave is to begin, when possible. When 30 days submission of the request form is not possible, submit the request as soon as possible. ISEA reserves the right to deny or postpone leave if you do not give adequate notice when permitted under federal and/or state law.

Employee Information

Please Print

Name: _____ Employee SS# _____

Job Title: _____ Assigned District: _____

Today's Date: _____ Hire Date: _____ Supervisor: _____

Reason for Requesting Leave

I am requesting family/medical leave for the following reasons: (check all that apply)

___ Birth of my child; to care for my newborn child
___ Placement of a child with me for ___ adoption ___foster care
___ Leave to care for a family member with a serious health condition
Relationship of family member to you: _____
___ My own serious health condition
___ 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
Relationship of family member to you: _____
___ Leave to care for a family member who is a current member of the Armed Forces (including the National Guard and Reserves) or a covered veteran and who is undergoing medical treatment, recuperation, or therapy, is in outpatient status or on temporary disability retired list for a serious injury or illness
Relationship of family member to you: _____
___ Other (please explain) _____
_____

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: _____
_____

Employee Certification and Signature

I certify that the above information is true an correct to the best of my knowledge:

Employee signature: _____ Date: ___/___/_____

EMPLOYER: This form should be treated as a medical record and must be maintained separately from employee personnel files, in locked cabinets with only designated personnel having access. As an employer, you should retain this original and provide a photocopy of the form to your employee along with the Notice of Eligibility and Rights and Responsibilities form within a reasonable period of time.