Employee Request for Leave
(To be completed by Employee)

Under the Family and Medical Leave Act, if you have worked at least one year and at least 1,250 hours in the past 12 months, you may be eligible for up to 12 weeks unpaid leave under specific circumstances. If qualified, you are entitled to receive health benefits as if you were still working. When returning to work, you are entitled to the same or equivalent job with the same pay, benefits and terms and conditions of employment. If you do not return to work following FMLA leave (for a reason other than the continuation, recurrence or onset of a serious health condition which would entitle you to FMLA leave or other circumstances beyond your control), you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

1. Name of Employee:

Last Name **First Name** **Middle Initial** **Date**

2. Employee's position/department:_____

3. Reason for requested leave (Please check the appropriate box):

A. <u>Family and Medical Leave (up to 12 weeks)</u>
Date you wish to commence leave _____
Date of anticipated return to work _____
1. ☐ Birth of my child and/or to care for the new born child.
2. ☐ Placement of child with me for adoption or foster care.
3. ☐ To care for my family member with a serious health condition
   ☐ spouse ☐ child ☐ parent
4. ☐ My own serious health condition.

B. <u>Intermittent Leave (up to 12 weeks FMLA)</u>
Date you wish to commence leave _____
Date of anticipated return to work _____
1. ☐ Birth of my child and/or to care for the new born child.
2. ☐ Placement of child with me for adoption or foster care.
3. ☐ To care for my family member with a serious health condition
   ☐ spouse ☐ child ☐ parent
   Name: _____
   Address: _____
   _____
4. ☐ My own serious health condition.

C. <u>Reduced Schedule (up to 12 weeks FMLA)</u>
Date you wish to commence leave _____
Date of anticipated return to work _____
1. ☐ Birth of my child and/or to care for the new born child.
2. ☐ Placement of child with me for adoption or foster care.
3. ☐ To care for my family member with a serious health condition
   ☐ spouse ☐ child ☐ parent
   Name: _____
   Address: _____
   _____
4. ☐ My own serious health condition.

Employee Request for Leave
(To be completed by Employee)

D. Military Qualifying Exigency Leave (includes up to 12 weeks of basic FMLA)

1. ☐ For
   ☐ spouse ☐ child ☐ parent ☐ next of kin
   Name: _____
   Address: _____
   _____
2. ☐ Short-notice deployment (up to 7 days of leave)
3. ☐ Attending military event: _____
   _____
4. ☐ Arranging for alternative childcare
5. ☐ Financial/Legal Arrangements
6. ☐ Counseling
7. ☐ Rest & recuperation for service member (up to 5 days of leave)
8. ☐ Attending post deployment activities (up to 90 days after termination of covered service member's active duty status)
9. ☐ Other activities arising of service member's active duty Or call to active duty agreed upon by company/employee
   _____
   _____

E. Leave to care for covered service member (up to 26 weeks, includes 12 weeks basic FMLA)

1. ☐ For
   ☐ spouse ☐ child ☐ parent ☐ next of kin
   Name: _____
   Address: _____
   _____

F. **Other Leave, not covered by FMLA**

1. ☐ Extended Medical Leave (leave exceeding an initial 12 weeks for employee's illness.

2. ☐ Personal Leave (Please state reason below)

_____
_____

3. ☐ Military Leave Covered Under **USERRA**
   Date you wish to commence leave _____
   Date of anticipated return to work _____