**Requests must be made, if practical, at least 30 days prior to the date the requested leave is to begin**.

Request Date

Name       ID

Title

Department

Hire Date       Employment Status: [ ]  Full-time [ ]  Part-time [ ]  Temporary

***(For Benefits Manager Use Only)***

 Actual Date of Birth:

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

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

[ ]  Due to the birth and care of my child.

Anticipated Date of Birth

Leave Start Date       Expected Return Date

[ ]  Due to the placement of a child with me for adoption or foster care.

Date of Placement

Leave Start Date       Expected Return Date

[ ]  To care for my [ ]  spouse, [ ]  child, or [ ]  parent who is experiencing a serious health condition.

Leave Start Date       Expected Return Date

[ ]  For a serious health condition that makes me unable to complete my job duties.\*

|  |  |
| --- | --- |
| Please describe: |       |

Leave Start Date       Expected Return Date

 *\*A physician’s certification is required for leave requested due to a serious health condition.*

[ ]  Request for intermittent leave (if applicable; subject to supervisor’s approval)

|  |  |
| --- | --- |
| ScheduleRequested: |       |

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

If yes, when?       How many workdays?

Supervisor Name

*Supervisor’s signature is not required, however you must inform supervisor of your leave request.*

Employee Signature Date

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **HR Leave Approval**Human Resources Signature Date

|  |  |
| --- | --- |
| Comments: |  |

**Payroll Instructions**[ ]  With pay from to under the Short-Term Disability Leave Policy.[ ]  Without pay from to under FMLA

|  |  |
| --- | --- |
| Comments: |  |

 |