**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)

|  |  |
| --- | --- |
| Schedule  Requested: |  |

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: |  | |