FAMILY MEDICAL LEAVE
REQUEST FOR LEAVE FORM

TO BE COMPLETED BY EMPLOYEE (Type or Print)

1. Name (First, Middle Initial Last).	2. Position.
3. Reason for requested leave: A. ☐ Birth of a son or daughter of the employee, and in order to care for such son or daughter. B. ☐ Placement of a son or daughter with employee for adoption or foster care. C. ☐ In order to care for spouse, child, or parent ("covered relation") with a serious health condition. D. ☐ Because of my own serious health condition which makes me unable to perform the functions of my position.	
4. If "C", please check one of the following: ☐ Spouse ☐ Child ☐ Parent	5. If "C", state name and address of relation.
6. Date on which you wish to commence leave.	7. Date of anticipated return to work.
8. Are you requesting leave on an intermittent or reduced leave schedule?	9. If "yes", please give schedule of when you anticipate you will be unavailable for work.

Employees seeking leave because of reason "3C" or "3D" above must complete the attached Medical Certification Form and return it within 15 days, or as soon as practicable. I understand that my leave may be delayed until I provide a completed Medical Certification Form.

Employees seeking to return to work after a leave because of their own serious illness (reason "3D") also must complete the attached Return to Work Medical Certification Form before they are allowed to resume work. I understand that I may not be permitted to resume my position until I provide a completed Return to Work Medical Certification Form.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse my employer for the cost of health benefits provided by the state during my leave, unless I fail to return to work because of the continuation, recurrence, or onset of a serious health condition. I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired or that I am needed to care for a covered relation because he/she has a serious health condition on the date that my leave expired and a written request for an extension of Leave Without Pay.

Signed _____ Dated _____

With few exceptions, you have the right to request, receive, review, and correct information about yourself collected using this form