

FMLA REQUEST

Employee's Name: _____

Supervisor's Name: _____

Requested Leave Start Date: _____

Requested Leave End Date: _____

The reason for this FMLA leave request is: *(check all that apply)*

The birth, adoption, foster placement of a child in my home.

My own serious health condition.

The serious health condition of my spouse, parent, or child.

Because of a qualifying exigency arising out of the fact that my spouse, parent, or child is on covered active duty or call to covered active duty status with the Armed Forces.

Because I am the spouse, parent, child, or next of kin of a covered service member with a serious injury or illness.

Time off is expected to be:

For a continuous block of time (several continuous days, weeks, or months off).

On an intermittent basis (periodic time off that is not usually expected to be the same days or time off from week to week).

Additional information about employee FMLA rights and responsibilities will be provided to you in writing within five (5) business days after receipt of this notice (unless already provided).

Determination of eligibility for leave under FMLA, and/or additional documentation of clarification of documentation, may be required prior to making a final FMLA determination to approve or deny any FMLA leave request. Please contact Debbie Wiirre in the Business Office with any questions.

Employee's

Signature: _____ Date: _____

Instructions: Fill out and sign form. Return to Debbie Wiirre in the Business Office.