Request for Family and Medical Leave

Employee Name: _________________________  Department: ______________________

I am requesting leave from _______________ to on or about ________________.

I understand I may be required to submit certification for this leave.

Reason for Leave:

☐ the birth of my child, or placement of a child with me for adoption or foster care.

☐ a serious health condition that makes me unable to perform the essential functions of my job.

☐ the serious health condition of my _____ spouse; _____ child; _____ parent for whom I am needed to provide care.

☐ a qualifying exigency arising out of the fact that my _____ spouse; _____ son or daughter; _____ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.

☐ I am the _____ spouse; _____ son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

I elect to use the following paid leave (if available) during my Family and Medical Leave:

☐ accrued vacation: ______ hours/days

☐ personal days: _______ hours/days

☐ accrued sick leave: _______ hours/days

☐ Short-Term Disability: _______ days/weeks

☐ parental leave: _______ days/weeks

___________________________________  ______________________________
Signature Date

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