EMPLOYEE LEAVE REQUEST FORM

You have a right under the Family Medical Leave Act (FMLA) of 1993 to receive up to twelve weeks of unpaid leave in a calendar year for the reasons listed below. To initiate a request for FMLA, please complete this form and a Leave Supplement Form and return them to the HR & Payroll Benefits Team at MSN 3C3.

Employee's Name (print)_____

G # _____Date of Request _____

Reason for Leave

- ☐ The birth of your child or placement of a child with you for adoption or foster care.
- ☐ A serious health condition that makes you unable to perform the essential functions of your job.
- ☐ A serious health condition affecting your ☐ spouse ☐ child ☐ parent for which you are needed to provide care.

Length of Leave

Leave Begin Date _____Return to work Date_____

OR

Intermittent Leave or Reduced Work Schedule: Begin Date _____

*** Please complete and submit your electronic timesheet at the end of each pay period.**

Leave Supplement :

Please complete a leave supplement form and return to the Benefits Department or the Benefits Administrator working with your current claim.

_____ _____
Employee's Signature Date

_____ _____
Supervisor's Signature Date

_____
Supervisor Name (Print)

_____ _____
Human Resources Signature Date

Please note: If your return date for your requested leave of absence changes, you must notify your Benefits Administrator or contact the Human Resources & Payroll Department on or before the date of return, in order to adjust any accrued vacation/unpaid days.