FAMILY AND MEDICAL LEAVE REQUEST FORM

Date: _____

I, _____, request family and medical leave for the following reason: (check all that apply)

☐ for the birth of my child;
☐ for the placement of a child for adoption or foster care;
☐ to care for my child who has a serious health condition;
☐ to care for my parent who has a serious health condition;
☐ to care for my spouse who has a serious health condition; or
☐ because I am seriously ill and unable to perform the essential functions of my position.
☐ because of "any qualifying exigency" arising out of the fact that my spouse, son, daughter, or parent is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.
☐ to care for a service member who is recovering from a serious illness or injury sustained in the line of duty on active duty who my spouse, son, daughter, parent, or next of kin.

I acknowledge my obligation to provide medical certification of my serious health condition or that of a family member in order to be eligible for family and medical leave within 15 days of the request for certification.

I acknowledge receipt of information regarding my obligations under the family and medical leave policy of the agency.

I request that my family and medical leave begin on _____ and I request leave as follows: (check one)

☐ continuous I anticipate that I will be able to return to work on _____.

☐ intermittent or reduced work schedule leave for the:

☐ serious health condition of myself, parent, or child when medically necessary

Details of the needed intermittent or reduced work schedule leave:

_____

_____

I anticipate returning to work at my regular schedule on _____ .

I realize I may be moved to an alternative position during the period of the family and medical intermittent or reduced work schedule leave. I also realize that with foreseeable intermittent or reduced work schedule leave, subject to the requirements of my health care provider, I may be required to schedule the leave to minimize agency operations.

While on family and medical leave, I agree to pay my regular contributions to employer sponsored benefit plans. My contributions shall be deducted from monies owed me during the leave period. If no monies are owed me, I shall reimburse the agency by personal check (cash) for my contributions. I understand that I may be dropped from the employer-sponsored benefit plans for failure to pay my contribution.

I agree to reimburse the agency for any payment of my contributions with deductions from future monies owed to me or the agency may seek reimbursement of payments of my contributions in court.

I acknowledge that the above information is true to the best of my knowledge.

Signed_____
Date_____