Employee Request For FMLA



I, _____, hereby request a leave for FMLA. **Please print name**

Effective date of leave:_____/_____/_____ I plan on returning to work on _____/_____/_____

QUALIFYING REASONS FOR LEAVE (please check reason for request)

The company will allow eligible employees to take Family Medical Leave for the following qualifying reasons:

- pregnancy or the birth of a child;
- the placement of a child with the employee for adoption or foster care;
- the serious illness* of the employee's child, stepchild, or ward who lives with the employee, foster child, parent, or spouse, or the employee's own serious illness.

The definition of a "Serious health condition" includes, but may not be limited to the following:

- Inpatient care: Care that requires an overnight stay in a hospital, hospice or residential medical care facility, including any period of incapacity or any subsequent treatment in connection with such inpatient care.
- Incapacity and Treatment: A serious health condition involving continuing treatment by a health care provider includes a period of incapacity of more than three consecutive full calendar days and any subsequent treatment or period of incapacity relating to the same condition.
- Pregnancy or Prenatal Care: Any period of incapacity due to pregnancy or for prenatal care.
- Chronic Conditions: Any eriod of incapacity or treatment for such incapacity due to a chronic serious health that requires periodic visits (at least twice per year) to a health care provider, continues over an extended period of time and may cause episodic rather than a continuing period of incapacity.
- Permanent or Long-Term Conditions: A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective, but requires continuing supervision of a health care provider.
- Conditions Requiring Multiple Treatments: Any period of absence to receive multiple treatments by a health care provider for (1) restorative surgery after an accident or other injury or (2) a condition that would likely result in a period of incapacity of more than three consecutive full calendar days without the treatments.

MILITARY FAMILY LEAVE:

- Military Caregiver Leave
- Qualifying Exigency Leave

I have been advised of my rights under FMLA.

I understand that when I return to work, I will be restored to my current position or a substantially equivalent position. I also understand that while I am on Family Medical Leave from XXX, I will be responsible for paying my share of the premiums for my benefits coverage for myself and for my dependents. Failure to do so may result in loss of coverage.

No other representations or promises regarding continued employment or job security have been made to me as I am an at will employee, free to resign at any time and capable of being terminated at any time with or with-out cause. I acknowledge that if I breach any of the representations contained herein above, or if my leave request is granted but the purpose or nature of the leave was misstated, the company has the right to discipline me up to and including immediate discharge.

_____Date: _____/_____/_____

Signature of Employee

_____Date: _____/_____/_____

Signature of Supervisor