Family And Medical Leave Act Checklist



Please complete a copy of this form for each FMLA-qualifying leave of more than (3) days or each FMLA qualifying leave.

Employee name: _____ Date: _____/_____/_____

Please print

Leave is for: ☐ Employee ☐ To care for a family member

If the request is for a family member, state relationship:

_____

Check all true statements:

☐ The employee has been employed for at least 12 months (does not have to be consecutive)

☐ The employee has worked at least 1,250 hours in the 12-month period immediately preceding the date of leave.

☐ The employee works in a position that requires at least 1,250 hours in a 12 month period

☐ The employee or family member has seen a health care provider (in the case of a serious health condition).

☐ A medical certificate has been supplied by the employee.

☐ The employee has been verbally and in writing told that the leave is to be counted as FMLA qualifying.

☐ The leave is for intermittent or reduced schedule leave.

☐ Take leave for periods of a particular duration, not to exceed the planned medical treatment; or

☐ Transfer temporarily to an available alternative position of equivalent pay and benefits in order to better accommodate recurring periods of leave.