City of Burlington
A Great Place to Live, Work and Play

REQUEST FOR FAMILY MEDICAL ACT LEAVE

Employee Name_____ Date of Request _____

Department _____ Position Title_____

Date Hired_____

I understand I will be placed on Family/Medical Leave for the following reason (check one):

_____The Birth of a child and in order to care for such child or the placement of a child for adoption or foster care

*_____*In order to care for an immediate family member if such family member has a serious health condition.*

*_____**In order to care for an immediate family member if such family member is a military service member, per City FMLA Plan.*

Circle one: CHILD SPOUSE PARENT

*_____*Employee's own serious health condition that makes the employee unable to perform the functions of his/her position.*

**Must submit Physician or Practitioner Certification within 15 days.*

***Must submit copy of Military Orders (Order to Active Duty or Discharge from Active Duty paperwork)*

*Method of Leave Requested - Consecutive Leave ____Intermittent or Reduced Leave _____***

_____

***Specify Schedule:_____*

Date leave is to begin: _____ Expected duration of leave: _____

If the duration of my family/medical leave (total of paid and unpaid time) does not exceed 12 weeks (26 weeks if caring for injured/ill service member per FMLA Plan), I will be returned to my same or equivalent position. I understand that if my family/medical leave should exceed 12 weeks, I will be returned to my same or similar position, only if available, in accordance with applicable laws. If my same or similar position is not available, I understand that under the FMLA Act I may be terminated.

_____ ***Original to HR – Copy to Supervisor***

Employee Signature Date