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

**To care for an immediate family member if such family member has a serious health condition.*

***To care for an immediate family member if such family member is a Military service member, per City FMLA Plan.*

Check 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* ***

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****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.

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Employee Signature *Date*

Original to HR – Copy to Supervisor