Family and Medical Leave Request Form

Date of Request:	
Employee Name	
Social Security Number	
Job Title	
Department	
Date hired	

Under the Federal Family and Medical Leave Act (FMLA), eligible employees are entitled to up to 12 (twelve) weeks of unpaid, job-protected leave for certain family and medical reasons. Please submit this request form to your supervisor at leave 30 (thirty) days before the leave is to begin, if possible. When submission of this form 30 (thirty) days in advance is not possible, submit the request as early as possible. The employer reserves the right to deny or postpone leave for failure to give appropriate notice whenever such denial or postponement would be permitted under federal or state law.

Eligibility	*Yes*	*No*
1. Have you worked for the company for a total of 12 months or more (whether or not consecutively)?		
2. During the past 12 months, have you worked at least 1,250 hours?		
3. Have you previously received medical or family leave*?*		
If yes: explain *Dates of previous leave:* *Purpose of previous leave:*		
4. Have you taken any intermittent leave?		
If yes: explain		
5. Have you taken other time off from your scheduled work?		
If yes: explain		

Check one	***Reasons for Requested Leave***	*Explanation*
	Serious health condition that makes you unable to perform your job	
	Serious health condition of child*,* spouse, or parent	
	Care for child after birth, adoption, or foster care	

If any circumstances change and I am unable to return to work on that date, I agree to inform my employer immediately in writing. I understand that my benefits will continue during my leave and that I will arrange to pay my share of any benefit premiums.

Signature of Employee

Date

Approved:	Denied:

Signature of Employer

Date