REQUEST FOR UNPAID FAMILY MEDICAL LEAVE

Employee Name: _____ Employee ID#: _____

Site/Department: _____ Position Title: _____

Hire Date: _____

I request a Family/Medical Leave for the following reason (check one):

A. _____ The birth of a child and /or in order to care for such child.
B. _____ The placement of a child for adoption or foster care.
C. _____ In order to care for an immediate family member because such family member has a serious health condition.
Circle one: CHILD – SPOUSE - PARENT
(Must submit "Physical Certification" within 15 days)

D. _____ Employee's own serious health condition that makes the employee unable to perform the functions of his/her position.
(Must submit "Physician Certification" within 15 days)

METHOD OF LEAVE REQUESTED

A. _____ Consecutive Leave
B. _____ Intermittent or Reduced Leave Schedule (Specify Schedule Below)

_____
_____
_____
_____

Date leave is to begin: _____ Date leave is to end: _____

Return to work date: _____

If the duration of my family/medical leave (total of paid and unpaid time) does not exceed 12 weeks, I will be returned to my same, equivalent, or comparable position. I understand that if my family/medical leave should exceed 12 weeks I will be returned to my same, equivalent, or comparable position, only if available. If my same, equivalent, or comparable position is not available, I understand that I may be terminated.

Employee Signature: _____ Date: _____

Employee Address: _____

_____

Employee Phone Number: _____