

REQUEST FOR FAMILY AND MEDICAL LEAVE OF ABSENCE

Employees who have worked for at least 1,250 hours during the 12-month period immediately before the request for leave are eligible for leave.

Name: _____ Department: _____

Supervisor: _____ Hire Date: _____

TYPE OF LEAVE REQUESTED

(Check one box)

- Employee Medical Leave of Absence
- Extension of Employee Medical Leave of Absence dates of prior approved medical leave are: _____ to _____.
- Family Medical Leave of Absence
- Extension of Family Medical Leave of Absence dates of prior approved medical leave are: _____ to _____.
- Leave to care for newborn or adopted child or a child placed for foster care by state procedures
- The leave or extension requested will begin on _____ and end on _____.

If the request is for multiple days off for recurring medical treatments of a child, parent, or spouse, for your own medical treatments, specify the dates requested:

REASON FOR LEAVE

I request a family leave of absence for the following reason:

(Check one box)

- My personal serious health condition
- Birth of my child
- Adoption of a child by me
- Placement by the state of a child with me for foster care
- Serious health condition of my child
- Serious health condition of my parent
- Serious health condition of my spouse

Employee Signature: _____ Date: _____