FAMILY AND MEDICAL LEAVE REQUEST FORM (FMLA)

INSTRUCTIONS FOR THE EMPLOYEE

- Complete the form and submit to Personnel Services – Benefits section (904-209-0636 fax)
- You will be notified as to whether the leave is approved or not.

EMPLOYEE INFORMATION

EMPLOYEE NAME _____ EMPLOYEE # _____

DEPT/DIV _____ DATE _____

TYPE OF LEAVE

I hereby request the following type of leave:

☐ Family leave for the:
- ☐ Birth of my son or daughter
- ☐ Placement of a child with me for: ☐ adoption ☐ foster care

Anticipated date of birth or placement: _____

☐ Family leave to care for a spouse, son daughter, or parent with a serious health condition

Family member's full name: _____

Relationship to you: ☐ spouse ☐ parent ☐ son or daughter ☐ other (if applicable)

Family member's address:

☐ Medical leave for my own serious health condition (specify):

I request the leave be granted for the following period of time:

Beginning on (date): _____ Ending on (date): _____

By signing below you agree to the following:

I hereby certify that the information given above is true and correct to the best of my knowledge. I understand that misrepresentation or omission of the reason for leave or any of the facts supporting the need for leave will result in denial of the leave and will subject me to discipline up to and including termination.

I understand that I must return this request with a note from my physician or a certification of health form before further action will be taken.

I certify that it is my responsibility to read the County's Leave policy on the intranet under the Administrative Code.

_____ _____

Employee Signature Department Head Signature

PERSONNEL SERVICES – BENEFITS USE ONLY

Has employee worked 12 months?
- ☐ YES
- ☐ NO

Has employee worked 1250 hours in last year?
- ☐ YES
- ☐ NO

_____ _____

Personnel Services Department Date