

MILITARY FAMILY AND MEDICAL LEAVE REQUEST FORM (FMLA)

INSTRUCTIONS FOR THE EMPLOYEE

- Complete the form and submit to Personnel Services – Benefits section (904-209-2414 fax)
- You will be notified as to whether the leave is approved or not.

EMPLOYEE INFORMATION

EMPLOYEE NAME _____ EMPLOYEE # _____

DEPT # _____ DATE _____

TYPE OF LEAVE

I hereby request FMLA leave for the following reason:

Leave to care for a family member who incurred an injury or illness in the line of military duty.

Family member's full name: _____

Relationship to you: spouse parent son daughter next of kin (describe)

Under this type of leave, eligible employees who are the spouse, son daughter, parent, or next of kin of a covered service member are entitled to take up to 26 weeks of unpaid, job-protected leave during a 12-month period to care for the service member.

Leave for a qualifying exigency due to a family member's active military duty or call to duty.

Relationship to you: spouse parent son daughter

Under this type of leave, eligible employees are entitled to up to 12 weeks of unpaid, job-protected leave during a 12-month period because of any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

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 copy of official orders or appropriate military certification for my request to be processed.

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