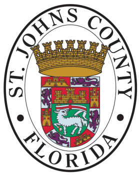

REQUEST FOR FAMILY AND MEDICAL LEAVE (FMLA)

Complete and submit this form to Human Resources Department.
Fax: 904.209.2414 **Email:** bccbenefits@sjcfl.us
You will be notified as to whether the leave qualifies as FMLA.

EMPLOYEE INFORMATION

Name: ______________________________ Employee ID#: ______________

Contact Info: ______________________________ **Job Title:** ______________

Immediate Supervisor: ______________________________ **Department:** ______________

REASON FOR REQUEST (*SELECT ONE*)

☐ Birth of child(ren) and to care for the newborn child(ren)

☐ Placement of child(ren) with me for: ☐ Adoption ☐ Foster Care

☐ Leave to care for family member with serious health condition: ☐ Spouse ☐ Child ☐ Parent

Family member's full name: ______________________________

☐ Leave due to my own serious health condition that makes me unable to perform the functions of my job

☐ Military caregiver leave due to a serious injury or illness of my covered military service family member:
☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Next of kin

Service member's full name: ______________________________

☐ Military qualifying exigency while my covered military service family member is on active duty status in support of a contingency operation as a member of the regular or reserve armed forces:
☐ Spouse ☐ Child ☐ Parent

Service member's full name: ______________________________

LEAVE TYPE REQUESTED (*SELECT ONE*)

☐ **I request continuous leave**. Requested Start Date: ____________ Anticipated End Date: ____________

☐ **I request intermittent leave**; periodic time off that is not expected to be the same from week to week.

Please use this area to further describe your leave request:

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 may result in the denial of the leave.
- I certify that it is my responsibility to read the Leave policy in the Personnel Section of the St. Johns County Administrative Code, available on the Intranet or from Human Resources.
- I understand that I must return provider certification of health and acknowledge that it is my responsibility if approved for FMLA to periodically report on my status and intent to return to work as directed by Human Resources.

Employee's Signature: ______________________________ **Today's Date:** ____________

To be completed by HUMAN RESOURCES - BENEFITS: *Date* received: ____________

Revised 12/2019