FMLA Request Form

The employee must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days is not possible, the employee must provide notice as soon as practicable and generally must comply with the location's normal call-in process.

Name: _____ Position: _____

Parish/School/Agency: _____

I hereby request that I be granted FMLA leave from _____/_____/_____ to _____/_____/_____ for

❑ FMLA/Employee ❑ FMLA/Family Member ❑ Military Caregiver ❑ Qualifying Exigency

_____

_____

_____

Employee Statement:

I understand that if granted a leave of absence as requested above, I am expected to return to work on or before ____/____/____. Should circumstances make it impossible for me to return by that date, I must let my employer know before the expiration of my original leave. I also understand the following:

1. I am still considered an employee while I am on leave.
2. If I accept other employment while I am on leave, even if temporary in nature, my employer will consider such action a voluntary termination of employment.
3. If I file a claim for Unemployment Compensation while I am on leave, my employer will consider such action to be my voluntary termination of employment.
4. My health, dental, short-term disability, long-term disability, and supplemental life insurance will remain in force while I am on leave if such benefits were in force prior to my going on leave. However, I must still remit my portion of the premium share costs for these benefits (if applicable).
5. My time spent on an approved leave of absence will be credited toward my accrued seniority.
6. I understand that if I return to work at the end of my approved leave, I will be reinstated to my original position or an equivalent position with equivalent pay, benefits and other terms of employment.
7. By requesting this leave of absence, I am stating my desire and intention to return to work within the prescribed timeframe.

8. I understand that if I am on a medical leave of absence my available sick time may be used for any medically necessary absences as certified by my physician.
9. I wish to utilize _____ days of my unused personal time and/or _____ days of my unused vacation time if I exhaust my available sick days to cover the medically necessary absence as certified by my physician while on a medical leave of absence.
10. I understand that my employer may require the use of my applicable paid time off benefits while I am on a leave of absence that extends beyond what is medically necessary.
11. I understand that if I am enrolled in benefits for which my dependants are also eligible for coverage and that if I am on a leave of absence for the birth or adoption of a child, I must submit new enrollment forms within 30 days of the birth or legal adoption/guardianship of the child if I wish to add him/her to my current coverage.
12. I understand that upon my return to work following a medical leave of absence I must provide my employer with a note from my physician authorizing my return to work.

Employee Signature: _____ Date: _____

❑ Approved ❑ Denied

_____ _____

Supervisor/Pastor/Administrator Date

CC: Human Resources

Processed in Payroll: _____