FAMILY LEAVE REQUEST FORM

TO BE COMPLETED BY EMPLOYEE:

Name: _____ Department_____

Pursuant to the Family and Medical Leave Act of 1993, I request an unpaid leave of absence from _____ to _____ for the following reason:

_____ birth/adoption/foster care of a child
(Indicate date of birth, adoption or foster care)
(Please attach legal documents for adoption or foster care.)

_____ personal serious health condition

_____ to care for a spouse, son or daughter or parent (circle one) who has a serious health condition
Name and relationship of family member you will care for

_____

If you are requesting a family leave to care for a seriously-ill family member, indicate the care you will provide and an estimate of the time period during which this care will be provided, including a schedule of time off if your leave is to be taken intermittently or on a reduced leave schedule.

If your leave request is for medical reasons, either for you or a family member, a health care provider must complete the statement on the reverse side.

Respectfully submitted,

_____
Employee Signature

_____
Date

Approved By:

_____
Department Head Date

_____
Personnel Officer Date

HEALTH CARE PROVIDER'S STATEMENT

1. *Patient's Name:* _____

2. *Date condition commenced:* _____

3. *Probable duration of condition:* _____

4. *Regimen of treatment to be prescribed (indicate number of visits, general nature and duration of treatment including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.):*

FOR CERTIFICATION RELATING TO CARE OF THE EMPLOYEE COMPLETE ITEMS 5 THROUGH 7, THEN SKIP TO ITEM 12.

	Yes	No	
5.	___	___	*Is inpatient hospitalization of the employee required?*
6.	___	___	*Is employee able to perform work of any kind? (If "No", skip Item 7.)*
7.	___	___	*Is employee able to perform some of his/her normal duties? (Answer after reviewing Statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.)*

Comments:

FOR CERTIFICATION RELATING TO CARE OF THE EMPLOYEE SERIOUSLY-ILL FAMILY MEMBER, COMPLETE ITEMS 8 THROUGH 12 BELOW AS THEY APPLY TO THE FAMILY MEMBER.

Patient's Name _____
Relationship to Employee _____

	Yes	No	
8.	___	___	*Is inpatient hospitalization of the family member (patient) required?*
9.	___	___	*Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?*
10.	___	___	*In your opinion is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.)*

11. *Estimate the period of time care is needed or the employee's presence would be beneficial:*

12. *Signature of Health Care Provider* _____

Date _____

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