Family and Medical Leave Act (FMLA) Request Form

To be completed by employee

Employee's Name	Department	Phone Number
Job Title		Employee ID

☐ Initial Application Home Phone #:

Reason for Leave of Absence

☐ Own illness (not work related) ☐ Pregnancy disability
☐ Care for ill parent/spouse/child ☐ Care for newborn/adopted child
☐ Other (specify)

☐ ☐

Requested start date	Anticipated end date	Requested intermittent or reduced work schedule

An FMLA leave of absence is a leave without pay. Paid leave (using accrued sick time or vacation hours) shall be substituted for the unpaid l eave in accordance with the Fam ily Medical Leave Act Policy.

I understand that I am required to use accrued paid time off until leave concludes or accrued balance is depleted. Below is an estimate of paid time off available in my account. Hours		Date Begins (mm/dd/yy)	Date Ends (mm/dd/yy)
	Accrued sick leave		
	Accrued vacation leave		
Employee's Signature		Date	