



HUMAN RESOURCES DEPARTMENT

EMPLOYEE REQUEST FOR FAMILY AND MEDICAL LEAVE (FMLA)

Rev: 3 | Date: 9/15/2022

Employee Name:	Department:	EE ID Number:	Date of Hire:
Supervisor:	Employee Phone Number:	Employee Personal Email:	

I am requesting FMLA Leave due to (check the appropriate boxes):

- 1. My own serious health condition
- 2. Need to care for family member due to their serious health condition. Family member:
 - Spouse Parent Child under age 18
 - Child 18 yrs. or older and incapable of selfcare for a mental or physical disability
- 3. A qualifying exigency, family member is on covered active duty or has been notified of an impending call or order to covered active duty status. Family member:
 - Spouse Parent Child
- 4. Need to care for family member who is a covered servicemember with a serious injury or illness. You are the servicemember's:
 - Spouse Parent Child Next of kin

Time off work to be: Continuous block of time Intermittent/reduced work schedule

Are you currently on FMLA or have used FMLA in the past 12 months? Yes No

If yes, please note that this new request does not extend the 12 weeks allowed under FMLA and approval will be based on the remaining leave balance.

I am aware, if FMLA is for my serious health condition, that I am required to provide Human Resources with a medical clearance note from my healthcare provider no later than one week before returning to work (**CHECK BOX**).

I request my FMLA to start on: _____ until _____

Employee Signature

Date

This form is to be submitted directly to the Human Resources Department, contact Human Resources at 954-828-5395.

DO NOT EMAIL MEDICAL DOCUMENTS