

FMLA REQUEST FORM

This FMLA Leave Request Form (hereinafter "Form") is submitted by the undersigned Employee to _____ (hereinafter "Employer") for the purpose of formally requesting leave under the Family and Medical Leave Act of 1993, as amended (29 U.S.C. § 2601 et seq., hereinafter "FMLA").

I. EMPLOYEE INFORMATION

Employee Name: _____

Employee ID Number: _____

Job Title: _____

Department: _____

Supervisor's Name: _____

Work Phone Number: _____

Work Email Address: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____

Personal Email Address: _____

II. REASON FOR LEAVE

Please check the box that applies to your reason for requesting FMLA leave. You may select more than one if applicable.

A. Employee's Own Serious Health Condition: For the Employee's own serious health condition that makes the Employee unable to perform the functions of their position.

B. Care for a Family Member with a Serious Health Condition: To care for the Employee's spouse, child, or parent who has a serious health condition.

C. Birth of a Child and Care of the Newborn Child: For the birth of a child and to care for the newborn child within one year of birth.

D. Placement of a Child for Adoption or Foster Care: For the placement with the Employee of a child for adoption or foster care and to care for the newly placed child within one year of placement.

E. Qualifying Exigency for Military Family Leave: Due to any qualifying exigency arising out of the fact that the Employee's spouse, son, daughter, or parent is a military member on covered active duty or call to covered active duty status (or has been notified of an impending call or order to covered active duty).

F. Military Caregiver Leave (Service Member with a Serious Injury or Illness): To care for a covered service member with a serious injury or illness if the Employee is the service member's spouse, son, daughter, parent, or next of kin.

III. LEAVE DETAILS

1. **Requested Leave Start Date:** _____ day of _____, 20 _____

2. **Requested Leave End Date:** _____ day of _____, 20 _____

3. **Type of Leave Requested:**

Continuous Leave: A single block of time away from work.

Intermittent Leave: Leave taken in separate blocks of time for a single qualifying reason.

Reduced Schedule Leave: Reducing the Employee's usual number of working hours per workweek or workday.

4. **If Intermittent or Reduced Schedule Leave, please provide details:**

Estimated frequency of leave (e.g., 2 days per week, 4 hours per day):

Estimated duration of each absence (e.g., 1-2 days, 4 hours):

5. Brief description of the reason for leave (e.g., nature of illness, expected treatment, care needed):

IV. FAMILY MEMBER INFORMATION (If applicable, for reasons B, C, D, E, or F)

Name of Family Member: _____

Relationship to Employee: _____

Date of Birth: _____ day of _____, 20 _____

Address (if different from Employee): _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

V. EMPLOYEE DECLARATION AND ACKNOWLEDGMENT

I understand that this request for FMLA leave is subject to review and approval by my Employer in accordance with the provisions of the Family and Medical Leave Act of 1993, 29 U.S.C. § 2601 et seq.,

and any applicable company policies.

I understand that I may be required to provide medical certification from a healthcare provider to support my request for leave due to a serious health condition (my own or a family member's) or for military caregiver leave. I agree to provide such certification within the timeframe requested by my Employer, typically fifteen (15) calendar days, or as soon as reasonably practicable. Failure to provide timely and complete certification may result in denial of FMLA leave.

I understand that for leave related to the birth or placement of a child, I must complete the leave within twelve (12) months of the birth or placement.

I affirm that the information provided in this Form is true and accurate to the best of my knowledge. I understand that any false statements or misrepresentations may result in disciplinary action, up to and including termination of employment.

I understand that my Employer will notify me of my eligibility for FMLA leave and my rights and responsibilities under the FMLA.

VI. EMPLOYER USE ONLY (DO NOT COMPLETE)

Date Request Received: _____ day of _____, 20 _____

FMLA Eligibility Confirmed: Yes No

Reason for Ineligibility: _____

Leave Approved: Yes No

Leave Denied: Yes No

Reason for Denial: _____

Leave Designated as FMLA: Yes No

Total FMLA Leave Entitlement Used (if applicable): _____ hours/weeks

FMLA Leave Remaining: _____ hours/weeks

Employer Representative: _____

Title: _____

Date: _____ day of _____, 20 _____

VII. GENERAL PROVISIONS

1. **Governing Law and Jurisdiction:** This Form and any disputes arising out of or related to it shall be governed by and construed in accordance with the laws of the United States, specifically the Family and Medical Leave Act of 1993, 29 U.S.C. § 2601 et seq., without regard to its conflict of laws principles.

2. **Severability:** If any provision of this Form is held to be invalid, illegal, or unenforceable by a court of competent jurisdiction, such provision shall be severed from this Form, and the remaining provisions shall remain in full force and effect.
3. **Entire Agreement:** This Form constitutes the entire agreement between the Employee and the Employer regarding the Employee's request for FMLA leave and supersedes all prior discussions, negotiations, and agreements, whether oral or written, relating to the subject matter hereof.
4. **Amendments:** Any amendment or modification to this Form must be in writing and signed by both the Employee and an authorized representative of the Employer.
5. **Notices:** All notices, requests, demands, and other communications required or permitted under this Form shall be in writing and shall be deemed to have been duly given when delivered personally, sent by certified or registered mail, return receipt requested, or sent by reputable overnight courier service, to the addresses set forth in this Form or to such other address as either party may designate by written notice to the other.
6. **Waiver:** No waiver of any provision of this Form shall be effective unless it is in writing and signed by the party against whom the waiver is asserted. The failure of either party to enforce any right or provision of this Form shall not be construed as a waiver of such right or provision.
7. **Headings:** The headings used in this Form are for convenience only and shall not affect the interpretation or construction of any provision hereof.
8. **Construction:** No presumption shall operate in favor of or against any party to this Form as a result of any responsibility for drafting this Form.
9. **Successors and Assigns:** This Form shall be binding upon and inure to the benefit of the Employee and the Employer and their respective heirs, successors, and permitted assigns.
10. **Counterparts:** This Form may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

EMPLOYEE

Signature: _____

Print Name: _____

Date: _____ day of _____, 20 _____

Address: _____

NOTARY PUBLIC ACKNOWLEDGMENT

STATE OF _____

COUNTY OF _____

On this _____ day of _____, 20_____, before me, a Notary Public in and for said County and State, personally appeared _____, known to me (or satisfactorily proven) to be the person whose name is subscribed to the foregoing instrument, and acknowledged that he/she executed the same for the purposes therein contained.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal.

Notary Public: _____

Print Name: _____

My Commission Expires: _____ day of _____, 20_____

(Seal)