HUMAN RESOURCES

CITY HALL
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Request for FMLA Leave

(Family Medical Leave Act)

Employee Name:		**Date of Request:**
Position Title:	**Department:**	**Hire Date:**

I am requesting FMLA Leave for the following reason (check one):

☐ The birth of a child and/or in order to care for such child

☐ The placement of a child for adoption or foster care

☐ In order to care for an immediate family member because such family member has a serious health condition. Check one: ☐ Child, ☐ Spouse, ☐ Parent ***(must submit "physician certification" within 15 days)***

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☐ Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. ***(Must submit a "Medical Certification - FMLA" completed by employee's physician)***

METHOD OF LEAVE REQUESTED

☐ Consecutive Leave

☐ Intermittent or Reduced Leave Schedule ***(Please specify schedule below)***

Date leave to begin:	**Expected duration of leave:**

______________________________________ ____________________

Employee's Signature **Date**