

Request for Family or Medical Leave

PLEASE PRINT

Request for Family or Medical Leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin.

Name: _____	Date: ____/____/____
Department: _____	Title: _____
Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time/Part Year <input type="checkbox"/> Temporary	Hire Date: ____/____/____
Hours per week _____	

I request Family or Medical Leave for one or more of the following reasons:

<input type="checkbox"/> Because of the birth of my child and in order to care for him/her. Expected Date of Birth ____/____/____ Actual date of birth ____/____/____ Leave to start ____/____/____ Expected return date ____/____/____

<input type="checkbox"/> Because of the placement of a child with me for the adoption or foster care. Date of placement. Leave to start ____/____/____ Expected return date ____/____/____
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<input type="checkbox"/> For a serious health condition that makes me unable to perform my job. Describe: _____ _____ Leave to start ____/____/____ Expected return date ____/____/____ <i>Physician's certification required</i>
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<input type="checkbox"/> In order to care for my <input type="checkbox"/> spouse, <input type="checkbox"/> child, or <input type="checkbox"/> parent, who has a serious health condition. Leave to start ____/____/____ Expected return date ____/____/____ <i>Physician's certification required</i>
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<input type="checkbox"/> Because of a qualifying exigency arising out of the fact that my <input type="checkbox"/> spouse, <input type="checkbox"/> son or daughter, <input type="checkbox"/> parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves. Leave to start ____/____/____ Expected return date ____/____/____

<input type="checkbox"/> Because I am the <input type="checkbox"/> spouse, <input type="checkbox"/> son or daughter, <input type="checkbox"/> parent or next of kin of a covered service member with a serious injury or illness. Leave to start ____/____/____ Expected return date ____/____/____ <i>Physician's certification required</i>
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Intermittent leave requested for above. Reason _____

Have you taken FMLA in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes how many work days? _____
<i>I understand and agree to the following provisions:</i>
<ul style="list-style-type: none"><i>I have worked for East Missouri Action Agency for at least one year and at least 1250 hours (832 hours for part year or part time employees) in the previous 12 months.</i><i>If I fail to return to work after the leave for reasons other than the continuation, recurrence, or onset of a serious health condition that would entitle me to Medical Leave or other circumstances beyond my control, I will be financially responsible for insurance premiums while I am on FMLA.</i><i>This leave will be unpaid or in the case of my own disability, I may be eligible for short term disability.</i><i>I must use all available paid leave (except for 5 days for full time or 4 days for part year/part year) in conjunction with FMLA.</i><i>After my 12 weeks (for full time) or 9 weeks (for part time/part year), if I do not return to work or contact my Supervisor/Program Director/Human Resources on the date intended, it will be considered that I abandoned my job.</i>
Employee Signature: _____ Date: ____/____/____

Program Director Signature: _____ Date: ____/____/____
Human Resource Signature: _____ Date: ____/____/____

Notes: _____ _____
