**Family and Medical Leave Act (FMLA) Request Form**

To request leave on the basis of the Family and Medical Leave Act (FMLA), please complete the following request form and submit to the Road Commission at least 30 days prior to leave (unless leave is unforeseen, in which case submit the form as soon as practical).

 Employee Name (print clearly): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requested Leave Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_          Estimated End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 The reason for this FMLA leave request is (select the most appropriate box):

❏   Birth of a son or daughter and to care for the newborn child, or placement with the employee of a child for adoption or foster care. Date of birth/placement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❏   To care for the employee's spouse, son, daughter or parent with a serious health condition.

❏   A serious health condition that makes the employee unable to perform the functions of the employee's job.

❏   A 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 has been notified of an impending call or order to covered active duty status).

❏   To care for a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent or next of kin of the covered service member.

Time off work is expected to be (select the most appropriate box):

❏   For a continuous block of time (several continuous days, weeks or months off work).

❏   For a reduced work schedule (change in work schedule needed—fewer hours per day or fewer hours per week).

❏   On an intermittent basis (periodic time off that is not usually expected to be the same days or time off from week to week; examples may be time off for flare-ups of a medical condition and/or for ongoing medical treatment/appointments).

If for a reduced work schedule or on an intermittent basis, please provide further detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Determination of eligibility for leave under the FMLA, and/or additional documentation or clarification of documentation, may be required prior to making a final FMLA determination to approve or deny an FMLA leave request. Please contact the Road Commission with any questions.

I understand that I am required to complete a FMLA Leave Certification of Health Care Provider form if my requested leave is due to a serious health condition and submit the form to the Road Commission before my leave commences. I request the following forms for my FMLA leave of absence:

1. Certification of Health Care Provider: This form is to be completed by either my health care provider (if this leave is for my own serious health condition) or by my family member’s health care provider (if this leave is for the serious health condition of a spouse, parent, or child). The health care provider must complete the entire form. **Failure to complete this form may delay or prevent my leave approval.**
2. Request to Return from FMLA Leave: I should fill out the top portion of the form, notifying the Road Commission of my date of return. For my own serious health condition, the bottom portion of the form (fitness-for-duty certification) should be filled out by my health care provider and returned to the Road Commission on or before the day I return to work from FMLA leave.

I understand that the Certification of Health Care Provider form should be returned to the Road Commission within 15 days. If I am not able to return the form within the allowed timeframe, I will contact the Road Commission for assistance.

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_           Date: \_\_\_\_\_\_\_

Return to Road Commission

For Road Commission use ONLY:

Date received: \_\_\_\_\_\_\_\_\_\_

FMLA Eligibility Notice sent: \_\_\_\_\_\_\_\_\_