**FMLA Leave Request Form**

**Employee Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name:** |  | | |
| **Employee ID:** |  | **Job Title:** |  |
| **Department:** |  | **Phone Number:** |  |
| **Email:** |  | | |

**Leave Request Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Type of Leave: | ☐ Continuous Leave | ☐ Intermittent Leave | ☐ Reduced Schedule Leave |
| Reason for Leave (check one): | ☐ Birth of a child / care for a newborn | ☐ Placement of a child for adoption or foster care | ☐ Care for a spouse, child, or parent with a serious health condition |
| ☐ Employee’s own serious health condition | ☐ Qualifying exigency due to a family member’s military service | ☐ Care for a covered service member with a serious injury/illness |
| Requested Start Date: |  | Expected End Date: |  |
| If intermittent/reduced schedule: Please explain proposed schedule: |  | | |

**Medical Certification**  
(Required for serious health condition of employee or family member)

|  |  |  |
| --- | --- | --- |
| Has certification been provided to HR? | ☐ Yes | ☐ No |

**Employee Acknowledgment**  
I certify that the information provided in this request is accurate. I understand that falsification of information may result in disciplinary action.

* Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_

**HR / Employer Use Only**

* Date Request Received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_
* Eligibility Verified: ☐ Yes ☐ No
* Certification Required: ☐ Yes ☐ No
* Certification Received: ☐ Yes ☐ No
* Leave Approved: ☐ Yes ☐ No
* If denied, reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* HR Representative Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_