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

**Purpose:** This form is used by employees to request job-protected leave under the Family and Medical Leave Act (FMLA) for childbirth, adoption, caregiving, military family leave, or a serious health condition.

**SECTION 1 — Employee Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Employee Name |  | Job Title |  |
| Department |  | Supervisor Name |  |
| Work Phone |  | Personal Phone |  |
| Email Address |  | Employee ID (Optional) |  |
| Hire Date |  |  |  |

**SECTION 2 — Type of FMLA Leave Requested**

(✓ Check the appropriate box)

**A. Employee’s Own Health Condition**

* ☐ Serious health condition preventing me from performing essential job duties

**B. Family Care Leave**

* ☐ Care for spouse with serious health condition
* ☐ Care for child with serious health condition
* ☐ Care for parent with serious health condition

**C. Parental Leave**

* ☐ Birth of a child
* ☐ Care for newborn child
* ☐ Adoption or foster care placement

**D. Military-Related Leave**

* ☐ Qualifying exigency for a family member on active duty
* ☐ Care for a covered service member with a serious injury/illness

**SECTION 3 — Leave Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Requested Start Date |  | Expected Return Date |  |
| Total Leave Requested |  | Is this intermittent leave? (✓ one) | ☐ Yes  ☐ No |
| If intermittent, describe the schedule | |  | |

**SECTION 4 — Reason for Leave (Brief Description)**

*(Do not include detailed medical information.)*

|  |
| --- |
|  |
|  |

**SECTION 5 — Required Documentation**

Please attach the appropriate documents (✓ what applies):

* ☐ Medical Certification (WH-380-E or WH-380-F)
* ☐ Birth or Adoption Documentation
* ☐ Military Orders / Exigency Certification
* ☐ Other Supporting Documents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION 6 — Use of Paid Leave (Employer Policy Applies)**

(✓ Check all that apply)

* ☐ I wish to use accrued **sick leave** during FMLA leave
* ☐ I wish to use accrued **vacation leave** during FMLA leave
* ☐ I wish to use **personal leave** during FMLA leave
* ☐ I request **unpaid leave** under FMLA

**SECTION 7 — Employee Acknowledgment**

I certify that the information provided is true and that I am requesting leave under the Family and Medical Leave Act. I understand that:

* The employer may require medical certification.
* FMLA leave may be unpaid unless eligible paid leave is applied.
* My job (or an equivalent job) is protected under FMLA.
* I must comply with employer call-in and documentation requirements.

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

**SECTION 8 — Employer / HR Use Only**

| **Field** | **Details** |
| --- | --- |
| Date Request Received | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| FMLA Eligibility Verified | ☐ Yes  ☐ No |
| Employee Meets 12-Month Requirement | ☐ Yes  ☐ No |
| Employee Meets 1,250 Hours Requirement | ☐ Yes  ☐ No |
| FMLA Request | ☐ Approved  ☐ Denied |
| Total FMLA Leave Approved | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Intermittent Leave Approved | ☐ Yes  ☐ No |
| HR Representative Name | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| HR Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |