

**FAMILY AND MEDICAL LEAVE ACT
APPLICATION / REQUEST / NOTIFICATION FORM**

EMPLOYEE NAME	EMPLOYEE #	DEPARTMENT
<p>I AM REQUESTING A LEAVE OF ABSENCE PURSUANT TO THE FAMILY MEDICAL LEAVE ACT FOR THE FOLLOWING REASON (CHECK ONE):</p> <p><input type="checkbox"/> THE BIRTH AND CARE OF A CHILD; OR</p> <p><input type="checkbox"/> THE PLACEMENT OF A CHILD WITH YOU FOR ADOPTION OR FOSTER CARE; OR</p> <p><input type="checkbox"/> MY OWN SERIOUS HEALTH CONDITION THAT RENDERS ME UNABLE TO PERFORM THE ESSENTIAL FUNCTIONS OF MY POSITION; OR</p> <p><input type="checkbox"/> A SERIOUS HEALTH CONDITION AFFECTING: <input type="checkbox"/> SPOUSE, <input type="checkbox"/> CHILD, <input type="checkbox"/> PARENT, FOR WHICH YOU ARE NEEDED TO PROVIDE CARE.</p>		
<p>I AM REQUESTING THE FOLLOWING LEAVE:</p> <p>DATE LEAVE WILL START: _____</p> <p>NUMBER OF WEEKS: _____</p> <p>INTERMITTENT LEAVE: (PLEASE SPECIFY DATES UPON WHICH LEAVE IS TO BE TAKEN)</p> <p>_____</p> <p>REDUCED SCHEDULE LEAVE: (PLEASE SPECIFY SCHEDULE REQUESTED) _____</p>		

Employee Signature: _____

Date: _____

APPROVED BY:

Supervisor

Date: _____

Director of Human Resources / Personnel

Date: _____