CITY OF FITCHBURG

Family and Medical Leave Act (FMLA) Request Form

To be completed by employee

Employee Name:	Department	Job Title:
Home Address:		Employee ID #:
☐ Initial Application	Home Phone:	Cell Phone:	**PERSONAL** E-Mail Address:

Reason for Leave of Absence

- ☐ Own illness (not work related)
- ☐ Care for ill parent/spouse/child
- ☐ OTHER/SPECIFY:
- ☐ Pregnancy disability
- ☐ Care for newborn/adopted child
- Date of Birth or Placement:

Answer all:

	Yes	No
Do you have City medical insurance?	☐	☐
Do you have City dental insurance?	☐	☐
Do you have other City insurance(s)?	☐	☐
Are you currently on another leave?	☐	☐
Have you or will you be filling a Disability insurance claim?	☐	☐

Requested start date	**Anticipated end date**	Dates of Rolling and/or Intermittent Leave OR reduced work schedule hours:

An FMLA leave of absence is a leave without pay. Paid leave (using accrued sick time, vacation or PTO hours) shall be substituted for the unpaid leave in accordance with the Family Medical Leave Act Policy.

I understand that I am required to use accrued paid leave, **with sick leave to be used first,** until leave concludes or accrued balance is depleted. Below is an estimate of paid time off available in my account.

HOURS	**or DAYS**		Date Begins (mm/dd/yy)	Date Ends (mm/dd/yy)
		Accrued Sick leave		
		Accrued Vacation leave		
		Accrued Personal leave		
Employee's Signature:			*Date:*	

I understand that I am required to complete a FMLA Leave Certification of Health Care Provider form and submit the form to Human Resources before my leave commences. I understand that if my leave is approved, my time away from work will be charged against my 12 week leave maximum under FMLA. Upon approval of this requested leave, I am required to utilize all paid time available to me prior to going into an unpaid leave status. In the event that I go into an unpaid status while on leave, I understand that I must contact Human Resources to make arrangements to pay my portion of health insurance premiums.

The following forms, if checked, are required to be completed and returned to Human Resources:

☑ 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). My physician must complete this entire form. ***Failure to complete this form may delay or prevent my leave approval.***

☑ Insurance Disclosure Agreement: This is an agreement between my employer and myself to continue my insurance benefits while on FMLA leave and a financial arrangement for my portion of health care premiums.

☐ Accrued Balances: This printed record is obtained from the department employee who completes your Departmental payroll. It must include your accrued balances for personal, sick and vacation time, as of the date of your completion of this Leave Request form.

☐ Request to Return From FMLA Leave: I should fill out the top portion of the form, notifying Human Resources of the date of my 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 Human Resources **NO LESS** than 3 business days prior to my return to work.

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

If this information is not received in the required time frame, my leave will be considered unauthorized.

Print Name	Employee Signature	Date