

REQUEST FOR FAMILY/MEDICAL LEAVE OF ABSENCE

DATE: _____

TO: Human Resource Department

FROM: _____
(Employee Name)

This is to request a Family and Medical Leave of Absence for the following reason (check one):

- ☐ the birth of a child in order to take care of the child (leave must be taken within twelve (12) months of the birth);
- ☐ the adoption or foster care placement of a child in order to care for the child (leave must be taken within twelve (12) months of the placement);
- ☐ a serious health condition affecting my ☐ spouse, ☐ minor/adult child, ☐ parent, because the ill person is not capable of self-care and I am needed for such care (see attached Certification of Health Care Provider); or
- X my serious health condition which results in my inability to perform my job (see attached Certification of Health Care Provider).

I wish to commence this leave of absence on _____. I anticipate that this leave of absence will end on_____.

Employee Signature