REQUEST FOR FAMILY OR MEDICAL LEAVE

Employee seeking (or confirming) a family or medical leave should check all applicable boxes, sign on reverse side, and submit to his/her supervisor at least thirty (30) days prior to the desired start date of the leave (if applicable) or as soon as possible if leave has already begun.

_____ requests leave or it was determined that
(Print Name)
leave was needed for the following reason:

❒ **Because of the (anticipated) birth of my child and in order to care for the child.**

❒ **Because of the placement of a child with me.**

- ❒ **For adoption**
- ❒ **For foster care**

❒ **In order to care for my**

- ❒ **Spouse**
- ❒ **Son / Daughter**
- ❒ **Parent**

❒ **Because of my own serious health condition that (will) makes me unable to work or unable to perform the functions of my job.**

❒ **Because of a qualifying reason arising out of the fact that my____ spouse; ____son or daughter; ____ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.**

❒ **Because I am the ____ spouse; ____son or daughter; ____ parent; ____ next of kin of a covered service member with a serious injury or illness.**

❒ **Because I am caring for my child if the child's school or place of care is closed or the child's care provider is unavailable due to public health emergency**

Anticipated (or actual) date _____ to start leave.
(actual date if leave has already begun)

Anticipated (or actual) date _____ to return to work.

Expected (or actual) date _____ of birth or placement of child.

❒ **I request that leave be granted on an intermittent or reduced work schedule basis for the following reasons: _____**

_____

_____

Proposed leave schedule: _____

_____

_____

I agree to:

- **Review all information in the box below for my information and for my required actions.**
- **Provide medical certification of need for leave, if applicable and requested.**
- **Provide documentation to confirm natural or legal family relationship if applicable and requested.**
- **Pay my share of group health care premiums, if applicable, by the required date while on leave.**
- **Report periodically regarding my status and intent to return to work.**
- **If applicable, provide medical certification of my fitness to work or inability to return to work at the end of my leave.**

Signature: _____ Date: _____

(Review Box Below)

TO BE COMPLETED BY THE COMPANY

Date of Employee Request or Notice of Need for Leave_____

Eligibility Requirements Met ❒ Yes ❒ No

Qualified FMLA Leave ❒ Yes ❒ No or ❒ Pending Certification of Documentation

Leave Designated ❒ Preliminary _____
(Date)

Leave Denied ❒ Delayed ❒ _____ Reason:_____
(Date)
_____

Requested Leave Schedule ❒ Approved ❒ Modified as follows: _____

_____

Medical Certification Request Date(s):

For Leave_____ Second Opinion_____ Third Opinion_____

Recertification(s)_____ Fitness/Inability to work _____
(Specify)

Confirming Document Requested_____
(Date)

Amount of remaining FMLA leave entitlement available for this request:_____

Accrued paid leave available for permissible substitution:_____ days.

Notification date of required/requested substitution:_____

Group Health Care Premiums_____
(Amount) (Due Date)

Pay to:_____

Signature (Preliminary)_____ Date_____

Signature (Final Disposition)_____ Date_____

Form RL-1
Revised 1/09

SESCO management consultants
P. O. Box 1848 - Bristol, TN. 37621
(423) 764-4127 Fax (423) 764-5869
www.sescomgt.com