CITY OF CARMEL
FAMILY & MEDICAL LEAVE ACT (FMLA) REQUEST FORM

INSTRUCTIONS – PLEASE READ CAREFULLY

This form must be submitted whenever FMLA leave is requested. It must be submitted at least 30 days in advance, if the need is foreseeable. In case of emergency, it must be submitted as soon as practicable. When this request is processed, you will receive a Notice of Eligibility and Rights & Responsibilities. Please read it carefully. At that time you may be required to submit a physician's certification or other documentation, depending upon the nature of your leave. You will have up to 15 calendar days to submit all required documentation, after which you will receive a Designation Notice advising whether your FMLA leave has been approved.

Please contact Sue Coy in Human Resources (571-5850) if you have any questions on FMLA.

COMPLETE SECTION I OF THIS REQUEST AND SUBMIT IT TO YOUR DEPARTMENT HEAD.

SECTION I – TO BE COMPLETED BY EMPLOYEE

Employee Name (First, MI, Last): *(please print)*	Department:

I hereby request the following type of leave: *(check where appropriate)*

☐ Family leave for the: (bonding time)

☐ Birth of my son or daughter

☐ Placement of a child with me for ☐ adoption ☐ foster care

Anticipated date of birth or placement: _____

☐ Family leave to care for a family member with a serious health condition

Relationship: ☐ spouse ☐ child ☐ parent ☐ other (if applicable)

Family member's full name: _____

Nature of care required: _____

☐ Medical leave for my own serious health condition (including pregnancy). Explain nature of condition: _____

_____

☐ Military Servicemember Care

☐ Qualified Military Exigency

☐ I request that the leave be granted for the following time period: (*this information is mandatory when requesting consecutive days of leave*)

Beginning on (date): _____ Ending on (date): _____

☐ I request that the leave be granted on an intermittent schedule (non-consecutive days). *You are required to provide as much notice as possible and to schedule appointments whenever possible on your days off to minimize the disruption of your department's work schedule.*

By my signature below, I certify that the above information is true and correct to the best of my knowledge. I understand that misrepresentation or omission of any facts related to this leave request may result in denial of the leave and subject me to discipline up to and including termination.

Employee Signature:	Date:

SECTION II – TO BE COMPLETED BY DEPARTMENT HEAD

Employee Hire Date:	Did employee work at least 1250 hours in previous 12 month period? ☐ Yes ☐ No
Has employee taken FMLA leave in the previous 12 month period? ☐ Yes ☐ No	
Department Head Signature:	Date:

SECTION III – TO BE COMPLETED BY DIRECTOR OF HUMAN RESOURCES

Director of Human Resources Signature:	Date