# TOWN OF BURLINGTON

*Human Resources Department*

## EMPLOYEE REQUEST FOR FAMILY OR MEDICAL LEAVE

**INSTRUCTIONS**

*Complete and submit this form to Human Resources. The Certification of your health care provider form must also be submitted. Both are due within 14 days of the first day of leave. You will be notified as to whether your leave is approved as FMLA. Information relating to approved or denied leave is set forth on the back of this form.*

**EMPLOYEE INFORMATION**

| Employee Name: | Location: |
|---|---|

**TYPE OF LEAVE**

I hereby request the following type of leave:

❑ Family Leave for the:
- ❑ 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 ❑ spouse ❑ parent ❑ son or daughter with a serious health condition

Family member's full name: Date of Birth:

Family member's address:

❑ Medical Leave for my own serious health condition (specify):

❑ Leave for a qualifying exigency 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.

❑ Servicemember Medical Leave for the serious injury or illness of my ❑ spouse; ❑ son or daughter; ❑ parent; ❑ next of kin who is a covered servicemember

**AMOUNT OF LEAVE**

I request that the leave be granted for the following period of time:

| Beginning on (date): | Ending on (date): |
|---|---|

(if applicable) I further request that the leave be granted for the following reduced or intermittent leave schedule:

I would like to use the following paid leave time during my family or medical leave:

Type: ❑ Vacation (# of days _______ ) ❑ Sick Leave (# of days _______ ) ❑ Compensatory Time (# of days _____ )

**EMPLOYEE CERTIFICATION AND SIGNATURE**

I hereby certify that the information given above is true and correct to the best of my knowledge. I understand that misrepresentation of the reason for leave or any of the facts supporting the need for leave will result in denial of the leave and disciplinary action up to and including discharge. I authorize my employer to obtain medical information from my physician.

Employee Signature: Date:

29 CENTER STREET • BURLINGTON, MASSACHUSETTS 01803 • TEL (781) 505-1160 • FAX (781) 238-4696
*www.burlington.org • hr@burlington.org*

**IF FMLA LEAVE HAS BEEN APPROVED**:

1. **PERIOD APPROVED AND EXTENSIONS.** Leave is approved only for the period designated. Where the period of leave requested is indefinite, the period of leave approved is no more than 30 calendar days from the date leave begins, unless otherwise stated on this form. You must request an extension of the leave if the leave will extend beyond the original period approved. Requests for extensions must be made at least three (3) days in advance of the date upon which the approved period expires, absent extenuating circumstances.
2. **EFFECT ON ENTITLEMENT.** The leave will be counted against your annual FMLA entitlement.
3. **CERTIFICATION REQUIRED.** If the leave is in connection with a serious health condition, you will be required to submit a confirming certification from a health care provider. For leave involving the birth of your child or the placement of a child with you for adoption or foster care, you must submit certification from a physician of the date of the expected birth, or from the appropriate authority regarding the anticipated adoption or foster care arrangement. These certifications must be submitted ***no later than 14 days from the date the leave is requested as shown on the front of this form.*** Failure to submit certification on a timely basis may result in the delay of leave approval or denial of leave.
4. **RECERTIFICATION REQUIREMENT.** Once the initial period of approved leave in connection with a serious health condition has expired, you will be required to provide a recertification by a health care provider every thirty (30) days. In its discretion, the Town may waive this requirement. If the requirement is waived, you will be notified.
5. **APPROVAL IS CONDITIONAL.** This approval of your FMLA leave is conditioned upon receipt of proper certification as set forth in (3) above (and re-certification, as set forth in (4) above, if applicable) on a timely basis, and will automatically become final upon timely receipt of certification which confirms the need for leave. If the certification is not timely, does not support the need for leave, or is otherwise defective, the Town reserves the right to either retract the approval of the leave or waive the certification requirement.
6. **SUBSTITUTION OF PAID LEAVE.** Substitution of other paid leave will occur as indicated on the front of this form, subject to availability as well as any collective bargaining agreements.
7. **BENEFITS COVERAGES:**

   **HEALTH & DENTAL INSURANCE:** Your health & dental insurance will remain in effect while on FMLA leave. You will be required to pay your normal employee contribution for coverage while on FMLA leave. To the extent you receive a paycheck while on leave your contribution amount will continue to be deducted from your paycheck. During any period for which your leave is unpaid, you must pay your contributions by the first of the month for the month of coverage. Failure to pay your contribution within the grace period may result in cancellation of your coverage. You will be notified prior to cancellation for non-payment. Upon return to work within the protected FMLA leave period, your coverage will be reinstated on a prospective basis without penalty. If you fail to return to work for other than reasons beyond your control, the Town may recover from you the entire cost of the coverage provided during your unpaid leave.

   **OTHER BENEFITS:** Your other benefit coverages **[life insurance, long term disability, etc.]** will continue only if you are on a paid FMLA leave. They will be reinstated on a prospective basis without penalty if you return to work within the protected FMLA leave period.
8. **FITNESS FOR DUTY REPORT.** If your leave for your own serious health condition exceeds five (5) consecutive work days, you will be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until the certification is provided.
9. **RETURN TO WORK.** If you return within the period of protected FMLA leave, you will be returned to your job or an equivalent job, unless you would have otherwise lost your job for reasons other than the leave (for example, a reduction in force.) If the circumstances of your leave change and you are able to return to work earlier than the date indicated above, you will be required to notify us ***at least two (2) work days*** prior to the date you intend to report for work. You may be permitted to return to work immediately, at the option of the Town. A release from your physician is required.

**IF FMLA LEAVE HAS BEEN DENIED:**

If your request for FMLA leave has been denied, you may file a request for reconsideration ***within 5 working days of the date of the denial***. The request must be in writing, stating the reason(s) why you believe the denial was in error, and providing appropriate certification(s) from a health care provider or other authority to support your statements. The Human Resources Office will respond to your request for reconsideration within 14 days of your request.