



## Family Medical Leave Act (FMLA) Request Form

### REQUEST

An Employee Requesting an FMLA will complete the information below and submit it to the Human Resources Coordinator for eligibility determination. Upon review, the HR department will respond with your determination within 5 days.

Employee's Name: \_\_\_\_\_

Please be advised that as of \_\_\_\_\_, I give you notice of my need to take FMLA due to:  
(Today's date)

- Birth or placement of a child for adoption or foster care.
- Serious health condition for which I need care.
- Serious health condition affecting my:
  - spouse,  child,  parent for which I am needed to provide care.
- Qualifying exigency arise from:
  - spouse,  child,  parent being on active duty or ordered to active duty in the Armed Forces.
- Need to care for a covered service member who is my:
  - spouse,  child,  parent,  myself or  next of kin.

I need this leave beginning on \_\_\_\_\_, and I expect the leave to continue until on/or about \_\_\_\_\_.

Employees Signature: \_\_\_\_\_

Date: \_\_\_\_\_