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Subset: Benefits

Subset: FMLA Checklist

Family and Medical Leave Act Checklist

Please complete a copy of this form for each FMLA-qualifying leave of more than (3) days or each FMLA qualifying leave.

Employee name: _____

Request is for: **Employee** ____ **To care for a family member** ____

If the request is for a family member, state relationship: _____

Check all true statements:

- The employee has been employed for at least 12 months (does not have to be consecutive)
- The employee has worked at least 1,250 hours in the 12-month period immediately preceding the date of leave.
- The employee works in a position that requires at least 1,250 hours in a 12 month period
- The employee or family member has seen a health care provider (in the case of a serious health condition).
- A medical certificate has been supplied by the employee.
- The employee has been verbally and in writing told that the leave is to be counted as FMLA qualifying.
- Is the leave for intermittent or reduced schedule leave?
 - take leave for periods of a particular duration, not to exceed the planned medical treatment; or
 - transfer temporarily to an available alternative position of equivalent pay and benefits in order to better accommodate recurring periods of leave.

This provision applies only in the instance of a foreseeable leave for which the employee has provided the employer with thirty (30) days, if practicable, notice.