

# FAMILY OR MEDICAL LEAVE REQUEST FORM

## INSTRUCTIONS FOR THE EMPLOYEE

- Complete the form and submit to appropriate supervisor / location director.
- You will be notified as to whether the leave is approved or not.

## EMPLOYEE INFORMATION

Employee Name: \_\_\_\_\_ Date Requested: \_\_\_\_\_

Position: \_\_\_\_\_ Program|Location: \_\_\_\_\_

**TYPE OF LEAVE** *I hereby request the following type of leave*

**PARENTAL BONDING LEAVE** [available to **Benefits Eligible Staff**]

**Parental Bonding, Medical or FMLA Family Medical Leave Act 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: \_\_\_\_\_

**NOTE:** Short Term Disability Claim to be initiated by a covered Female Employee with an expectant birth.

**\*FAMILY MEDICAL LEAVE** [if eligible] *\*Additional Medical Certification will be required for these FMLA Leave Requests*

- Family leave to care for a spouse, son, daughter, or parent with a serious health condition
- Family member's full Name: \_\_\_\_\_
- Relationship to you: spouse parent son or daughter other (if applicable)
- Medical leave for my own serious health condition (specify): \_\_\_\_\_
- Service-member Care
- Exigency Leave

**AMOUNT OF LEAVE** \*ALL MEDICAL/PARENTAL LEAVE RUNS CONCURRENTLY WITH SCHEDULED HOLIDAYS, SUMMER BREAK & FMLA LEAVE AS APPLICABLE

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

Beginning on (date): \_\_\_\_\_ Ending on (date): \_\_\_\_\_

**FMLA Eligible only:**

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

*\*I recognize that my accrued leave banks will be paid out during any FMLA leave [\*except in the case that I am receiving disability or W/C payments] and when exhausted, my leave will be unpaid.*

NOTE: Health Insurance premiums are automatically deducted while in a pay status. Payment is required by employee during non-pay status.

## 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 mis-representation or omission of the reason for leave or any of the facts supporting the need for leave may result in denial of the leave and could result in disciplinary action, up to and including the release of my employment.*

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

Supervisor's Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

## MAINTAIN THIS FORM IN A CONFIDENTIAL MEDICAL FILE

### OFFICE USE ONLY

Leave Approved?  Yes  No

For what period \_\_\_\_\_ Expected Return Date: \_\_\_\_\_ Parental Bonding Paid Leave thru: \_\_\_\_\_

Additional Leave, if eligible: \_\_\_\_\_ STD pay offset, if applicable: \_\_\_\_\_

Medical Certification / Birth Certificate Requested: \_\_\_\_\_ Returned: \_\_\_\_\_ Notice of Leave Approval to Employee: \_\_\_\_\_

cc> Employee

Payroll/HR Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# ADMINISTRATIVE STEPS | PARENTAL BONDING LEAVE

EMPLOYEE: \_\_\_\_\_ POSITION: \_\_\_\_\_ PROGRAM/ LOCATION: \_\_\_\_\_

1. **EMPLOYEE COMPLETES LEAVE REQUEST FORM** and SUBMITS TO LOCATION SUPERVISOR
  - a. Advance notice of at least 30 days is requested \_\_\_\_\_  
DATE REQUESTED
2. **LEAVE REQUEST IS REVIEWED BY APPROPRIATE ADMINISTRATOR**
  - a) Parental Bonding Leave available to Benefits Eligible employees [as defined in Handbook]
3. **SUPERVISOR APPROVES LEAVE AS APPROPRIATE**
  - a) **NOTIFY EMPLOYEE** of 6 Weeks paid time off available for Parental Bonding Leave beginning with the birth/placement
  - b) **Provide Short Term Disability Claim info to be initiated by a covered Female Employee** with an expectant birth
  - c) IF employee is FMLA leave eligible working for a covered location, up to 6 additional weeks of leave available for a total of 12 weeks
  - d) FMLA leave certification should be requested for those who qualify and work for a covered entity
  - e) **\*\*ALL ACCRUED LEAVE BALANCES [vacation & sick] WILL BE PAID OUT before going to UNPAID STATUS**  
**\*\*With the EXCEPTION of when a Staff member is receiving Disability or W/C payments [follow carrier's requirements]**
  - f) Health Insurance premiums are automatically deducted while in a pay status. *Payment is required by employee during non-pay status.*

**AMOUNT OF LEAVE** \*ALL MEDICAL/PARENTAL LEAVE RUNS CONCURRENTLY WITH SCHEDULED HOLIDAYS, SUMMER BREAK & FMLA LEAVE AS APPLICABLE

**(1) LEAVE REQUESTED:**

Beginning on (date): \_\_\_\_\_ Ending on (date): \_\_\_\_\_

**(2) LEAVE APPROVED:**

Beginning on (date): \_\_\_\_\_ Ending on (date): \_\_\_\_\_

**(3) NOTICE OF LEAVE APPROVAL TO EMPLOYEE:** \_\_\_\_\_

AS APPLICABLE Medical Certification / Birth Certificate Requested: \_\_\_\_\_ Returned: \_\_\_\_\_

## PAYROLL DEPT | LEAVE PAYMENT PROCESSING

**HR | PAYROLL USE ONLY**

Leave Approved?  Yes  No

Actual Date Leave Begins: \_\_\_\_\_ Paid Parental Bonding Leave thru: \_\_\_\_\_

STD PAY OFFSET, IF APPLICABLE: *Week 5 and 6 of PBL, Disability dates approved by Medical Provider*

**SHORT TERM DISABILITY PAY OFFSET: Manual adjustment in IOI | Disability Insurance paying 60% of wages**

Rate prior to offset: \$ \_\_\_\_\_ Adjusted amount [Weeks 5 & 6]: \_\_\_\_\_  
[40% of full rate]

Rate returned to regular amount: \$ \_\_\_\_\_  
*at conclusion of STD offset*

Additional Leave, if eligible: \_\_\_\_\_ Accrued Paid Leave applied: \_\_\_\_\_

ACTUAL RETURN to WORK DATE: \_\_\_\_\_ Payroll/HR: \_\_\_\_\_ Date: \_\_\_\_\_

*Completed by Signature*

Site Administrator Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_