REQUEST FOR FAMILY/MEDICAL LEAVE

Employee Name: ______________________________ Date of Request: ___________

Department: _________________________________ Position Title:_______________

Hire Date: ____________________________________

I request a Family/Medical Leave for the following reason (check one):

A. The birth of a child and/or in order to care for such child.

B. The placement of a child for adoption or foster care.

C. In order to care for an immediate family member because such family member has a serious health condition. Please check one of the following:

Child Spouse Parent Domestic Partner

(Must submit "Physician Certification" within 15 days.)

D. Care for an adult child who is incapable of self-care. (A child is "incapable of self-care" if he/she requires active assistance or supervision to provide daily self- care in three or more of the activities of daily living or instrumental activities of daily living, such as caring for grooming and hygiene, bathing, dressing and eating, cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, etc.).

E. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position.

F. To assist a child, spouse, or parent who is a member of the Armed Forces, including the National Guard or Reserves with a "qualifying exigency" related to covered active duty or a call of active duty status. Please check one of the following:

Child Spouse Parent Domestic Partner

(Must submit "Physician Certification" within 15 days.)

G. To care for a child, spouse, parent or "next of kin" covered service member of the United States Armed Forces who has a serious injury or illness incurred or aggravated in the line of duty while on active duty (up to 26 weeks of leave). Please check one of the following:

Child Spouse Parent

(Must submit "Physician Certification" within 15 days.)

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Method of Leave Requested

A. Consecutive Leave

B. Intermittent or Reduced Leave Schedule (Specify schedule below)

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Date leave is to begin: _______________ Expected duration of leave: _______________

If the duration of my family/medical leave (total of paid and unpaid time) does not exceed 12 weeks (or 26 weeks to care for an injured service member), I will be returned to my same or equivalent position. I understand that if my family/medical leave should exceed 12 weeks (or 26 weeks to care for an injured service member), I will be returned to my same or equivalent position, only if available. If my same or equivalent position is not available, I understand that I may be terminated.

Date: ____________________

Employee' Signature: ____