Employee FMLA Leave Request

(Family and Medical Leave Request Form)

DIOCESE OF ST AUGUSTINE
The Catholic Church of North Florida

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to take up to 12 (26 weeks to care for a covered member of the military) of job-protected leave for certain family and medical reasons. Submit this request form to the Human Resources Department at least 30 days before the leave is to begin, when possible. When 30 days' advance notice is not possible, submit the request as soon as possible.

Employee Information

Employee Name: _____ **Today's Date:** _____

Department: _____ **Job Title:** _____

Date of Hire: _____ **Status:** ☐ Full-Time ☐ Part-Time **Supervisor:** _____

Reason for FMLA (check all that apply):

☐ Birth of my child; to care for my newborn/adopted child

☐ Own illness/serious health condition (not work-related)

☐ Placement of a child with me for: ☐ adoption ☐ foster care

☐ Other. Explain: _____

☐ Care for a family member with a serious health condition. Relationship: ☐ spouse ☐ child ☐ parent

☐ Qualifying exigency for a family member on covered active duty or has been notified of an impending call to order to covered active duty in the armed forces. Relationship: ☐ spouse ☐ child ☐ parent

☐ Care for a covered military service member or veteran recovering from an illness or injury suffered while on active duty in the armed forces that existed before the beginning of the member's active duty and was aggravated by service or that manifested itself before or after the member became a veteran. Relationship: ☐ spouse ☐ child ☐ parent

Duration of Leave

Leave expected to begin: _____ **Leave expected to end:** _____

If intermittent or reduced-leave schedule is being requested, please explain why it is needed and the proposed leave schedule:

An FMLA leave of absence is a leave without pay. Paid leave (using accrued sick time and/or vacation/personal hours) shall be substituted for the unpaid leave in accordance with the Family Medical Leave Policy.

I understand that I am required to use accrued paid time off until leave concludes or accrued balance is depleted. Below is an estimate of paid time off available in my account:

_____ **Remaining Sick Leave Hours**

_____ **Remaining Personal Leave Hours**

_____ **Remaining Vacation Leave Hours**

Employee Certification and Signature

I understand that I am required to complete an FMLA Leave Certification of Health Care Provider form and submit to my FMLA Administrator before my leave commences. I understand that, if approved, my time away from work will be charged against my 12-week leave maximum under FMLA and that I am required to utilize all paid time available to me prior to going into an unpaid leave status. In the event that I go into an unpaid status while on leave, I understand that I must coordinate with my FMLA Administrator to make arrangements to pay my portion of health insurance premiums. I understand that the Certification of Health Care Provider form should be returned to the FMLA Administrator within 15 days of receipt and, if not received in the required timeframe, my leave may be considered unauthorized.

_____ _____

Employee Signature Date

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