

Request for Leave Family and Medical Leave Act (FMLA)

Employee Name

Workday ID Number

Mailing Address

City, State and Zip

Home/Cell Number

Email Address

Supervisor Name

Supervisor Email Address

Department/Work Location/County

Work Number

Requested FMLA Begin Date

Requested FMLA End Date

FMLA Type:

- ☐ Block of Time/Continuous FMLA
- ☐ Intermittent FMLA
- ☐ Reduced Schedule FMLA (Schedule Requested: _____)

I am requesting FMLA for:

- ☐ Birth of a child, or Placement of a child for adoption or foster care
(Expected delivery date or placement date: _____)
- ☐ For a serious health condition that makes me unable to work
- ☐ To care for a child, spouse, or parent with a serious health condition
(Provide family member's name and relationship: _____)
- ☐ Military: Qualifying exigency for a spouse, child or parent
(Please provide the family members name and relationship: _____)
- ☐ Military: Caregiver leave for a spouse, child, parent or next of kin
(Please provide the family members name and relationship: _____)

Employee's Signature

Date

Supervisor's Signature

Date

HR Office Use Only:

Date Received: _____

Approval/Denial Notice Date: _____

Date of ADA Referral (if applicable): _____

**Supervisor's signature is for acknowledgment of the FMLA request only. The Office of Human Resources will determine FMLA eligibility and approval of each request.*