THE ARCHDIOCESE OF KANSAS CITY IN KANSAS

FMLA LEAVE REQUEST FORM

Employee:	*Department / Parish / Institution:*

This is to request leave under the Family and Medical Leave [a] Act due to:

- ❑ the birth and care of my newborn child
- ❑ the placement of a child for adoption or foster care in my household
- ❑ care for a spouse, child, or parent with a serious health condition [b]
- ❑ my inability to work because of a serious health condition [b]
- ❑ a qualifying exigency arising from the fact that my spouse, child, or parent is on active duty or call to active duty status as a member of the National Guard or Reserves in support of a contingency operation
- ❑ Other (please explain) _____

_____

For a Serious Health Condition, please provide enough information to determine if FMLA Leave applies to your situation:_____

_____

_____

Date(s) Requested:

Beginning Date: _____ Ending Date: _____

[a] **Family and Medical Leave -** A maximum of 12 weeks per 12-month rolling period is allowed for Family Medical Leave of Absence. ELIGIBILITY – Has been employed by the employer for 12 months and worked at least 1, 250 hours of service during the 12-month period immediately preceding the commencement of FMLA leave.

[b] **Important Note Regarding Leave Due to Serious Health Condition –** A certification form will be provided for you to submit to the health-care provider to complete. The completed from must be returned to your employer within 15 calendar days from the date that you submit this request.

Employee's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____