Employee FMLA Leave Request

(Family Medical Leave Request Form)

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to take up to 12 weeks of job-protected leave for certain family and medical reasons per 12-month period.

Employees do not have to share a medical diagnosis but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Employers can require a certification or periodic recertification supporting the need for leave.

Submit this form to your Human Resource's Manager at least 30-days before the leave is to begin (when possible). Submit the request as soon as possible when the 30-day advance submission is not possible. Switchpoint reserves the right to deny or postpone leave if request is not received or adequate notice given under the federal and/or state law.

Employee Information (Please print)

Name: ____ Department: _____________________________

Supervisor: _______________________________________ Job Title: ______________________________________

Today's Date: ____/____/_______ Hire Date: ____/____/_______ Status: ☐ Full-time ☐ Part-Time ☐ Temporary

Reason for Requested Leave (Check all that apply)

☐ Birth of my child and/or to care for my newborn child
☐ Placement of a child with me for ☐ Adoption ☐ Foster Care
☐ Leave to care for a family member with a serious health condition. Relationship: ____________________________
☐ My own serious health condition
☐ Other Qualifying Reason (Please specify) ____

Duration of Leave (How long do you expect to be out?)

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 schedule:

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PTO or Unpaid Leave (Do you have and wish to use PTO for this leave?)

☐ I will take *Unpaid leave ☐ Use my PTO for my leave. Please apply _______ hours of PTO each week of my leave.

*If you are taking Un-Paid Leave and are a full-time employee with benefits, you will be responsible to pay your portion of your insurance premiums when they are due in order to keep your benefits. (See *Keeping Your Benefits during LOA*)

Employee Certification and Signature

I certify that my supervisor is aware of this request and that the above information is true and correct to the best of my knowledge:

Employee signature: ____ Date: ____/____/_______

Date Submitted: ____/____/_______ Approved by: ____________________ Date Approved: ____/____/_______