Pay Plus BENEFITS

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EMPLOYEE REQUEST FOR FAMILY OR MEDICAL LEAVE

Employee Name | **Company**

Federal Family and Medical Leave is available to eligible employees (employed at a worksite where 50 or more employees are employed by the employer within a 75 mile radius of that worksite) with at least 12 months of service and who have worked at least 1,250 hours in the 12 months preceding the first day of the leave. Employees on USERRA leave will have those hours counted toward the 1,250-hour requirement, but other forms of leave such as holiday hours, sick leave, and workers' compensation leave will not be included. If eligible, an employee may be able to take up to 12 work weeks of unpaid leave that do not have to be consecutive during a 12-month period (based on a 12-month rolling cycle) for the following reasons: 1) The birth of a child or to care for a child within the first 12 months after birth; 2) The placement of a child with the employee for adoption or foster care within the first 12 months of placement; 3) To care for an immediate family member (child, spouse, or parent) who has a serious health condition; or 4)For a serious health condition that makes the employee unable to perform the essential functions of his/her position; 5) For any "qualifying exigency" (as defined by federal regulation) because the employee is the spouse, son, daughter, or parent of an individual on active military duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation; or 6)To care for a service member who is recovering from a serious illness or injury sustained in the line of duty on active duty.

Please refer to the Federal Family and Medical Leave section of your Employee Handbook for a complete description of the policy.

NAME: _____

REQUESTED LEAVE TIME: From _____ To _____

THIS REQUEST IS FOR **ORIGINAL** _____ or **EXTENSION** _____ or **INTERMITTENT LEAVE**_____

REASON FOR REQUEST:

_____ The birth of your own child or the placement of a child with you for adoption or foster care; or
_____ A serious health condition affecting your ____spouse ____child ___parent, for which you are needed to provide care; or
_____ Your own serious health condition that makes you unable to perform the essential functions of your job; or
_____ Because an individual has been called to active military duty or has been notified of an impending call; or
_____ To care for an injured or ill service member

Please sign, date and submit the completed form to your supervisor.

_____ _____
EMPLOYEE SIGNATURE DATE