

**REQUEST FOR LEAVE UNDER THE  
FAMILY AND MEDICAL LEAVE ACT OF 1993**

(Submit Completed Form to Human Resources Department)

NAME \_\_\_\_\_ DEPARTMENT \_\_\_\_\_

**Type of Leave Requested:**

*Continuous* (Start Date \_\_\_\_\_; End Date \_\_\_\_\_)

*Intermittent* (List Frequency and Length of Expected Absences):

\_\_\_\_\_

\_\_\_\_\_

*Reduced Schedule* (Indicate Days, Hours, Duration):

\_\_\_\_\_

**Reason for Leave:**

For Birth of a Son or Daughter and to Care for the Newborn Child

For Placement With You of a Child for Adoption or Foster Care

To Care for Your Spouse, Son, Daughter or Parent With a Serious Health Condition

Because of a Serious Health Condition That Makes You Unable to Perform Your Job

Explanation (include relationship of family member, description of serious health condition, etc.):

\_\_\_\_\_

\_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Department Head Signature \_\_\_\_\_ Date \_\_\_\_\_

Eligible

Not Eligible ( \_\_\_\_\_ )

HR Director Signature \_\_\_\_\_ Date \_\_\_\_\_