Family and Medical Leave Act (FMLA) Request Form

To be completed by employee:		
Employee Name:	Department/School:	Job Title:
Address:		Phone #

Reason for Leave of Absence:	Answer all questions below:
☐ Own illness (not work related)	Yes No
☐ Pregnancy disability	☐ ☐ Do you have company medical insurance?
☐ Care for ill parent/spouse/child	☐ ☐ Do you have company dental insurance?
☐ Care for adopted/newborn child (DOB) ____________	☐ ☐ Do you have company vision insurance?
☐ Military FMLA Leave	☐ ☐ Are you currently on another leave?
☐ Other (please specify below):	☐ ☐ Have you or will you be filling a disability insurance claim?

Requested Start Date:	Anticipated End Date:	Type of leave: ☐ Continuous Leave ☐ Intermittent Leave
How would you like to be your FMLA status?	☐ Regular Mail ☐ Email/Phone	Email Address:

- I understand that I am required to complete the FMLA Certification of Health Care Provider Form (this will be mailed or emailed to you if applicable) and submit the form to the Benefit Specialist in the Human Resources Department **before** my leave begins.
- I understand that the Certification of Health Care Provider form must be returned to Benefit Specialist within 15 **days**. If this information is not received in the required timeframe, my leave will be considered unauthorized and any absences will be counted as unapproved absences.
- I understand that if I am not able to return the form within the allowed timeframe, I will contact the Benefit Specialist and or Human Resources Department for assistance.
- I understand that if my FMLA leave is approved, my time away from work will be charged against my 12 week leave annual maximum under FMLA.
- I understand that upon approval of this requested leave, I am required to use all accrued PTO available prior to going into an unpaid leave status.

Acknowledgement:

Employee Signature: ____ **Date**: ____________________________

For questions or concerns about FMLA leave, please contact Tracie Aldridge, Benefit Specialist at 918-684-3700 Ext: 1632

Email: tracie.aldridge@roughers.net

An FMLA leave of absence is a leave without pay. Paid leave (using accrued sick time or vacation hours) shall be substituted for the unpaid leave in accordance with the Family Medical Leave Act Policy.

TO BE FILLED OUT BY PAYROLL:	**Estimate of days as of:**	
# of accrued sick days		
# of accrued personal days		
# of accrued vacation days		
# of state days		

Human Resources Approval ____ Date: ___________________________