MEDIC
Medical Excellence. Compassionate Care.

FMLA REQUEST FORM

UPON SUBMISSION OF THESE FMLA DOCUMENTS, IN THE EVENT YOU MUST CALL OUT DUE TO FMLA REASONS, YOU MUST FOLLOW CALL-OUT POLICY AND YOU MUST EMAIL FMLA@MEDIC911.COM WITHIN 24 HOURS

Please complete this form in its entirety and submit it to Human Resources for evaluation prior to your leave of absence or whenever possible.

Employee Name: _____ Employee ID No: _____

Department: _____ Supervisor: _____

Date of Hire: _____ Status: ☐Full Time ☐ Part Time Shift:_____

Reason for requested leave (check one main box):

☐ Birth and Bonding:
For the ☐ birth of a child ☐ adoption of a child ☐ placement of a foster child, and to care and bond with the child within one year

☐ Due to my own serious health condition which makes me unable to perform my essential job functions

☐ To care for my ☐ spouse ☐child ☐parent with a serious health condition
If your request is to care for your child, please indicate the child's birthdate (mm/dd/year): _____

☐ Qualifying military exigency due to active duty of my ☐ spouse ☐ child ☐parent

☐ To provide care for a qualifying service member/veteran

TYPE OF LEAVE REQUESTING (check one box and fill in blanks):

☐ **Regular leave beginning** _____ (date) with return to work on _____ (date).
Last Day Worked: _____
(For purposes of FMLA, "regular leave" occurs when an employee takes off from work for a continuous, uninterrupted block of time for a qualifying reason or serious health condition.)

☐ **Intermittent Leave beginning** _____(date) to _____ (date).
(For purposes of FMLA, "intermittent leave" occurs when an employee takes intermittent time off from work due to a single qualifying reason or serious health condition, but then returns to work for a period of time and then again takes intermittent time off due to the same qualifying reason or serious health condition. This entitles an employee to take off intermittent periods due to "chronic "or "lifetime" condition when medically necessary, for qualifying reasons and/or for treatment of a serious health condition.)

☐ **Reduced Leave** of_____ hours from _____ to_____. (List period of time)
(For purposes of FMLA, "reduced leave" occurs when an employee reduces their current schedule to accommodate their serious health condition.)

Employee Acknowledgement:

I certify that all of the information provided by me on this form is accurate and true to the best of my knowledge. I realize that the providing of false information on this form is falsification of a company document and could result in formal corrective action or separation of employment. My signature below authorizes my employer, Medic, to obtain any and all information that is necessary to determine the eligibility of this request for leave

_____ _____
Employee Signature Date

You may be eligible for Paid Family Leave if you are on approved FMLA and need to take time to bond with a new child or to care for a seriously ill child, parent or spouse. For more information please review Policy 4.8 in the Employee Handbook or contact a member of Human Resources at HumanResources@medic911.com. Paid Family leave must be taken in one continuous block. You may not work any other job nor work any hours at Medic including but not limited to in-service while on Paid Family Leave.