HUMAN RESOURCES DIVISION
FAMILY AND MEDICAL LEAVE REQUEST FORM

To Be Completed By Employee

Employee Name:_____ Date of Request:_____

Full Mailing Address:_____

Home Phone:_____ Work Phone:_____

Division:_____ Supervisor:_____

Job Title:_____

- Have you taken FMLA during the past 12 months? Yes No
  If yes, when did you take the leave?_____
- If your spouse works for the City, have they taken FMLA leave during the past 12 months?
  Yes No If Yes, what is your spouse's name?_____

  *For leave related to the birth or placement of a child, eligible spouses who work for the same employer are limited to a combined total of 480/672 hours of leave in a 12-month period to share (480 hours or 672 hours for Fire on 2912 schedule).
  - If Yes to above, does your spouse intend to utilize FMLA hours as well? Yes No
- Do you work for the Fire Department? Yes No
  - If Yes, which schedule do you work? 2080 2912
    2080 schedule is eligible for 480 hours, 2912 schedule is eligible for 672 hours

1. REASON FOR LEAVE

The birth of your child or placement of a child with you for adoption or for foster care
The need to care for spouse, child, or parent who has a serious health condition
Name of Family Member_____Relationship_____
My own serious health condition that prohibits me from performing the essential functions of my job. *You may be subject to a fitness-for-duty physical (to assess your ability to perform the essential functions of your job) before being allowed to return to work.
To care for a Service Member or Veteran who has been injured in the line of duty
To manage affairs while a service member of the National Guard, Reserves or Armed Forces is on covered active duty in support of a contingency operation

5. INSURANCE BENEFITS

-While on paid leave, benefit costs will continue to come out of your paycheck.

-While on unpaid leave under FMLA, you will need to contact Payroll at 213-2200 to make arrangements to directly pay for your benefits

This includes employee only benefits and dependent benefit coverage and all types of coverage (health, voluntary life insurance and disability)

Employee Acknowledgment

By signing below, I certify that I have read the City of Flagstaff Family and Medical Leave of Absence Policy 1-50-050 and that I agree to abide by the requirements of the Policy.

Employee Signature:_____ Date:_____