HUMAN RESOURCES DIVISION
FAMILY AND MEDICAL LEAVE REQUEST FORM

To Be Completed By Employee

Employee Name_____ Date of Request_____

Mailing Address_____
Street/Box City State Zip

Home Phone_____ Office Phone_____

Division_____ Supervisor Name_____

Position Title_____

Have you taken FMLA during the past 12 months?
☐ No ☐ Yes If yes, when?_____

If your spouse works for the City, has he/she taken FMLA during the past 12 months?
☐ No ☐ Yes If yes, name of spouse and dates when leave was taken?_____
☐ Not applicable

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 12 workweeks of leave in a 12-month period to share (480 hours and 672 hours for Fire).

- Does your spouse intend to utilize FMLA hours as well? ☐ No ☐ Yes
- If Yes, has he/she taken FMLA during the past 12 months? ☐ No ☐ Yes
- Name of Spouse and dates when leave was taken: _____

1. REASON FOR LEAVE

Select the reason for requesting FMLA:

☐ 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
☐ 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

2. HEALTH CARE PROVIDER'S CERTIFICATION

☐ I have completed and attached the certification
☐ I will provide the certification within 15 calendar days
☐ I have provided a certification for Exigency Leave giving specific frequency or duration

3. LENGTH OF LEAVE REQUESTED

Select the type and length of FMLA requested:

Start Date_____ End Date_____

☐ Full-time leave

☐ Intermittent or reduced schedule leave*.

List specific dates, times, or schedules you are requesting

_____

_____

**Employees needing an intermittent/reduced schedule must work with their employer to schedule the leave to not unduly disrupt the employer's operations (subject to the approval of the health care provider.) In such cases the employer may transfer the employee temporarily to an alternative job with equivalent pay and benefits that accommodates recurring periods of leave better than the employee's regular job.*

4. COMPENSATION WHILE ON LEAVE

While on FMLA leave I choose to use the following accruals (number the leaves to be used in priority order and the number of hours to be used):

Priority Order	Type of Leave	Number of Hours to be Used
_____	Sick	_____
_____	Vacation	_____
_____	Compensatory Time	_____
_____	Floating Holiday	_____
_____	Personal Day	_____
_____	Holiday	_____
_____	Sick Industrial	_____
_____	Leave Without Pay	_____
_____	Parental Leave	_____
_____	Other	_____
_____	Donated Leave*	_____

*Donated Leave may only be used after all other leaves have been exhausted.

5. INSURANCE BENEFITS

If you currently have dependent health insurance, are you continuing coverage?

☐ Yes

- While on paid leave, the dependent premiums will continue to come out of your paycheck.
- While on unpaid leave, you will need to contact Payroll at 213-2200 to make arrangements to pay for the dependent insurance premiums.

☐ No

☐ Not applicable

If you currently have voluntary life insurance for you or your dependents do you want to continue coverage?

☐ Yes

- While on paid leave, the dependent premiums will continue to come out of your paycheck.
- While on unpaid leave, you will need to contact Payroll at 213-2200 to make arrangements to pay for the dependent insurance premiums.

☐ No Will reinstate upon return to work or at the end of 12 weeks, whichever comes first.

Employee Acknowledgment

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

Employee signature:_____ Date:_____