

**CITY OF GREENFIELD
REQUEST FOR FAMILY MEDICAL LEAVE**

Employee Name: _____

Date of Request: _____

Position Title: _____

Department: _____

SSN#: _____

Eligible employees are entitled under the FMLA to up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons. Submit this request form to your supervisor at least 30 days before the leave is to commence; or if not practicable, as soon as is practicable. The City reserves the right to deny or postpone leave for failure to give appropriate notice when such denial/postponement would be permitted under federal or state law.

I request a Family/Medical Leave for the following reason (check one):

- _____ A. The birth of a child and in order to care for such child or the placement of a child for adoption or foster care.

- _____ B. In order to care for an immediate family member if such family member has a serious health condition. _____
(Print relationship of family member)
(Must submit "Physician or Practitioner Certification" within 15 days).

- _____ C. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. (Must submit "Physician or Practitioner Certification" with 15 days).

Method of Leave Requested (You may select consecutive initially and switch to Intermittent or Reduced Leave in the same request. Please indicate appropriate duration in each if known. You may write TBD if length is unknown as long as you notify Human Resources once you know.)

_____ A. Consecutive Leave _____(weeks)

_____ B. Intermittent or Reduced Leave Schedule (Specify Schedule Below)

_____ (weeks)

Substitution of Paid Leave

Family Medical Leave is unpaid leave in the first instance. Paid leave may be substituted for unpaid Family Medical Leave by using accruals however, upon exhaustion of any available accruals, the leave then becomes unpaid.

Please elect your preference(s) below:

_____ A. Unpaid Leave

_____ B. Paid leave for birth, adoption, or foster care placement of a child (any accrued sick, vacation, personal leave, and compensatory time may first be substituted for unpaid family/medical leave. Please number in what order of usage you are choosing with “1” being the first choice).

- ___ Vacation time
- ___ Personal time
- ___ Sick time
- ___ Comp (if applicable)

_____ C. Paid leave for your own serious health condition or to care for a covered family member, any accrued **sick** leave may first be substituted for unpaid family/medical leave. If your sick leave totals less than the twelve (12) week leave period, then personal, vacation and compensatory leave may be substituted for unpaid leave. (If you elect paid leave, sick time will be substituted first then any accrued vacation, personal leave, and compensatory time may first be substituted for unpaid family/medical leave. Please number in what order of usage you are choosing with “1” being the first choice).

- 1 Sick time
- ___ Vacation time
- ___ Personal time
- ___ Comp (if applicable)

Date leave is to begin: _____

Expected duration of leave: _____

The total number of days of leave I request is: _____

If the duration of my family/medical leave (total of paid and unpaid time) does not exceed 12 weeks, I will be returned to my same or equivalent position. I understand that if my family/medical leave should exceed 12 weeks I will be returned to my same or similar position, only if available, in accordance with applicable laws. If my same or similar position is not available, I understand that I may be terminated.

I agree to return to work on _____. If circumstances change such that I will not be able to return to work on that date, I agree to inform my supervisor by submitting a NOTICE TO EMPLOYER OF CHANGES IN APPROVED MEDICAL OR FAMILY LEAVE form. I understand that my benefits will continue during my leave and that I will arrange to pay my share of applicable premiums.

Employee Signature: _____ Date: _____

TO BE COMPLETED BY SUPERVISOR

Hire Date: _____ Employee is Full-time
Part-time

Regular hours are: _____ on _____ days of the week for a total of _____ hours.

How will employee's duties and responsibilities be handled during the leave?

Employee has previously requested family or medical leave on _____.

Leave taken from _____ to _____. Total hours taken: _____.

Supervisor: _____ Date: _____.

TO BE COMPLETED BY HUMAN RESOURCES

Prior leave requests confirmed: _____

Leave is: Approved

Postponed / Denied for the following reasons: _____

Signature: _____

Date: _____