CITY OF BROCKTON

Family and Medical Leave Act (FMLA) Request Form

To be completed by employee:

Employee Name:	Department	Job Title:
Home Address:		Employee ID #:
☐ Initial Application	Home Phone:	Cell Phone:	**PERSONAL** E-Mail Address:

Reason for Leave of Absence

☐ Own illness (not work related)
☐ Care for ill parent/spouse/child
OTHER/SPECIFY:
☐

☐ Pregnancy disability
☐ Care for newborn/adopted child
Date of Birth or Placement:

Answer all:

	Yes	No
Were you on FMLA prior to this request?	☐	☐
Are you currently on FMLA?	☐	☐

If yes, please list effective dates: _____

Are you currently on another leave? If so, list the type of leave and effective dates:_____ _____ **Yes** ☐ **No** ☐

Requested start date	**Anticipated end date**	Dates of Rolling and/or Intermittent Leave OR reduced work schedule hours:

An FMLA leave of absence is a leave without pay. In accordance with the City of Brockton's FMLA Policy, an employee has the option of using accrued time which shall be substituted for the unpaid leave of absence.

I understand that I am required to exhaust all available sick time during this leave and I also understand, it is my sole discretion to use any accrued and unused paid time off including personal time, compensatory time, time due and/or vacation time.			Date Begins (mm/dd/yy)	Date Ends (mm/dd/yy)
HOURS	**or DAYS**			
		Accrued Sick leave		
		Accrued Personal, Compensatory, Time Due leave		
		Accrued Vacation leave		
Employee's Signature:			*Date:*	

To be signed by Department Head:

By signing below, I have been informed of the request for Family Medical Leave and confirm (if applicable) the accruals as stated above are correct and to the best of my knowledge. I also understand by signing this form it does not constitute an approval or denial for leave.

Department Head signature: *Date:*

To be acknowledged and signed by employee:

I understand that I am required to have a completed FMLA Certification of Health Care Provider Form which my physician shall submit directly to Human Resources and it is also my responsibility to submit an Insurance Disclosure Agreement to Human Resources before my leave commences. I understand that if my leave is approved, my time away from work will be charged against my twelve (12) week leave maximum under FMLA per calender year.

Upon approval of this requested leave:

☐ I will utilize all paid time available to me.

☐ I will not utilize paid time and, if and when my sick time is exhausted, this leave will be unpaid.

In the event that I go into an unpaid status while on leave, I understand that I must comply with the terms of the Insurance Disclosure Agreement and continue to pay my portion of health insurance premiums while on unpaid leave.

I also understand that my physician shall submit directly to Human Resources the Certification of Health Care Provider form within fifteen (15) calender days. If my physician is unable to return the form within the allowed time frame, I will contact Human Resources for assistance.

If the above information is not received in the required time frame, my leave may be considered unauthorized.

Print Name _____ Employee Signature _____ Date _____