Medical Leave of Absence Form

Section One (to be completed by employee):

Employee's Name	Department
Job Title	
Contact Number:	Email address:

***Reason for Leave of Absence (LOA)*:**

Please select only one.

- ☐ Own illness (not work related)
- ☐ Care for ill parent/spouse/child
- ☐ This is a work related case
- ☐ This is a work related case. I will not be using my accrued time. Once removed from the payroll, I cannot request to use any benefit time until I return to work.
- ☐ Pregnancy disability
- ☐ Care for newborn/adopted child (Date of Birth/Placement)

Answer all:	**Yes**	**No**		**Yes**	**No**
Do you have County medical insurance?	☐	☐	Are you currently on another leave?	☐	☐
Do you have County dental insurance?	☐	☐	Have you or will you be filing a Disability insurance claim?	☐	☐

Requested start date	Anticipated end date	Requested intermittent or reduced work schedule

An FMLA leave of absence is a leave without pay. Use of sick time runs concurrently with FMLA time. Paid leave shall be substituted for the unpaid leave in accordance with the Family Medical Leave Act Policy. If any additional sick time is accrued, it cannot be used again while out on this medical LOA.

I understand that I am required to use accrued paid time off beginning with sick, and I elect addition accrued time to be used as follows until leave concludes or accrued balance is depleted. Below is an estimate of paid time off available in my account.	Date Begins (mm/dd/yy)	Date Ends (mm/dd/yy)	# of days
Accrued sick hours			
Accrued vacation hours			
Accrued personal hours			
Accrued comp hours			
Holiday hours			
Employee's Signature	Date		

I understand that I am required to complete a FMLA Leave Certification of Health Care Provider form and submit the form 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 12 week leave maximum under FMLA. Upon approval of this request leave, I am required to utilize all sick time available to me prior to going into an unpaid leave status. In the event that I go into an unpaid status while on leave, I understand that I must contact Human Resources to make arrangements to pay my portion of health insurance premiums.

Continue reading on the back, print and sign.

Member Request Form Filing Instructions and Information:

1. Certificate of health Care Provider: This form is to be completed by either my health care provider (if this leave is for my own serious health condition) or by my family member's health care provider (if this leave is for the serious health condition of a spouse, parent, or child). My physician must complete the entire form. **Failure to complete this form may delay or prevent my leave approval.**
2. Continuation of Benefits While on FMLA Leave: This is an agreement between my employer and myself to continue my benefits while on FMLA leave, and I shall still be responsible for my employee portion of health care premiums. I understand that if I do not qualify under FMLA, I may be eligible for continued health insurance coverage under COBRA.
3. Notification of FMLA Status (Approval/Denial): This is to notify me that my employer is designating the leave as FMLA leave and to inform me in writing of the specific excitations and obligations required by my employer under FMLA.
4. Request to Return From FMLA Leave: I should fill out the top portion of the form, notifying Human Resources of the date of my return. For my own serious health condition, the bottom portion of the form (fitness-for-duty certification) should be filled out by my Health Care Provider and returned to Human Resources on the day I return to work from FMLA leave.

   I understand that the Certification of Health Care Provider form should be returned to Human Resources within 15 days. If I am not able to return the form within the allowed timeframe, I shall contact Human resources for assistance.

   If this information is not received in the required timeframe, my leave will be considered unauthorized.

   I further understand that if I am out of work continuously for one year or more for a disability or cumulatively for one year or more due to a work-related injury, my employment status may be terminated under Civil Service Law.

_____ _____

Print Name Employee Signature

Section Two (to be filled out by Department Head):
Note: This section is not to approve or deny FMLA.

☐ I have assessed the effect on the department and the information provided has been approved.
☐ I have assessed the effect on the department and the information provided has been denied based on the following:

_____
_____
_____

SIGNATURE:_____ DATE:_____