Coastal Protection & Restoration Authority

Employee FMLA Leave Request Form

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to take up to 12 or 26 weeks of job-protected leave for certain family and medical reasons. Submit this request form to Human Resources at least 30 days before the leave is to begin, when possible. When 30 days advance submission of the request form is not possible, submit the request immediately. For additional information, please refer to CPRA Policy #24 Family and Medical Leave Act or contact Human Resources.

Employee Information:

Name: _____ Personnel #: _____

Division: _____ Job Title: _____

Reason for Requesting Leave:

I am requesting family/medical leave for the following reason: (*Select the most appropriate box*)

12 weeks:

☐ Birth of my child; to care for my newborn child

☐ Placement of a child with me for ☐adoption ☐ foster care

☐ Leave to care for a family member (Parent, Child, and Spouse) with a serious health condition
Relationship of family member to you: _____

☐ My own serious health condition

26 weeks:

☐ Qualifying exigency because a family member is on or has been called to covered active duty in the Regular Armed Forces (including the National Guard and Reserves) to a foreign country
Relationship of family member to you: _____

☐ Leave to care for a family member who is a current member of the Armed Forces (including the National Guard and Reserves) or a covered veteran and who is undergoing medical treatment, recuperation, or therapy, is in outpatient status or on temporary disability retired list for a serious injury or illness
Relationship of family member to you: _____

☐ Other (*please explain*)

_____

_____

Duration of Leave:

Estimated amount of leave needed: _____

Date leave expected to begin: _____ Date leave expected to end : _____

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If intermittent or reduced-leave schedule is being requested, please explain why it is needed and the proposed leave schedule:

_____

_____

Employee Certification and Signature:

I understand that I am required to obtain a FMLA Leave Certification of Health Care Provider form from Human Resources to be certified by a physician and returned 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/26 week leave maximum under FMLA.

Upon approval of this requested leave, I am required to utilize all paid time available to me, as applicable, 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 discuss payment of my health insurance premiums.

I certify that the above information is true and correct to the best of my knowledge:

_____ _____

Employee Signature **Date**

For HR use ONLY:

Date received: _____ Employed 12 months: _____

Full-time: _____ Worked 1,250 hours: _____

FMLA approval email: _____ Timekeeper email: _____

Return to work required: _____