FAMILY AND MEDICAL LEAVE AUTHORIZATION FORM – 5 to 10 days off

Employees who have worked for at least 1,250 hours during the 12-month period immediately prior to this request for FMLA leave are eligible for FMLA leave.

Name ____ T-Number _________________________

Department ____ Hire Date __________________________

TYPE OF LEAVE REQUESTED

Check one box:

[ ] Employee Family and Medical Leave
[ ] Extension of previously taken Employee Family and Medical Leave
Previous days taken were ___________________________
[ ] Leave to care for newborn or adopted child or child place (via state procedure) for foster care

The Leave will begin on __________________________ and end on _____________________________

Reason for Leave (list any medical conditions, etc, relating to the absence):
____
____
____
____
____

REASON FOR LEAVE

I request family and medical leave for the following reason (check one box):

[ ] My personal serious health condition
[ ] Serious health condition of my child
[ ] Serious health condition of my parent
[ ] Serious health condition of my spouse
[ ] Birth of my child
[ ] Adoption of a child by me or placement of a child with me for foster care
[ ] Servicemember leave for a “qualifying exigency”
[ ] Servicemember leave to care for a family member injured in the line of military duty

I understand that this time off will be recorded as FMLA time off and count towards said time off for the current year.

____
Employee Signature

____
Date

CERTIFICATION OF A PHYSICIAN OR PRACTIONER

(You may use the following or ask your doctor for a certification of diagnosis and release)

Employee's Name ____

Patient's Name ____

Diagnosis____
____

Date condition commenced _________________ Probable duration of condition ____________________

Regiment of treatment to be prescribed (indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatments if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week:

By Physician or Practitioner: ____
____
____
____

By another provider of health services, if referred by Physician or Practitioner: ______________________
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____
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For care relating to the employee's serious health, complete the following:

Is inpatient hospitalization of the employee required? [ ] Yes [ ] No

Is employee able to perform work of any kind? [ ] Yes [ ] No

Is employee able to perform the functions of the employee's position?
(answer after reviewing statement by employer of essential functions
of the position or after discussing with employee) [ ] Yes [ ] No

Printed Name of Physician or Practitioner ____

Signature of Physician or Practitioner ____

Field of Specialization or Type of Practice ____

Address ____ Date ______________________

For care relating to a family member's serious health, complete the following:

Is inpatient hospitalization of the family member (patient) required? [ ] Yes [ ] No

Does or will the patient require assistance for basic medical
Hygiene, nutritional needs, safety or transportation? [ ] Yes [ ] No

Estimate the period of time care is needed or the employee's presence would be beneficial:

____

Printed Name of Physician or Practitioner ____

Signature of Physician or Practitioner ____

Field of Specialization or Type of Practice ____

Address ____ Date _____________________

TO BE COMPLETED BY EMPLOYEE:

When Family and Medical Leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced schedule:

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