



HUMAN RESOURCES DIVISION FAMILY AND MEDICAL LEAVE REQUEST FORM

To Be Completed By Employee

Employee Name: _____ Date of Request: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____

Division: _____ Supervisor: _____

Job Title: _____

- Have you taken FMLA during the past 12 months? Yes No
If yes, when did you take the leave? _____

- If your spouse works for the City, has he/she taken FMLA leave during the past 12 months?
Yes No If Yes, what is your spouse's name? _____

*For leave related to the birth or placement of a child, eligible spouses who work for the same employer are limited to a combined total of 480/672 hours of leave in a 12-month period to share (480 hours or 672 hours for Fire on 2912 schedule).

- If Yes to above, does your spouse intend to utilize FMLA hours as well? Yes No
- Do you work for the Fire Department? Yes No
 - If Yes, which schedule do you work? 2080 2912
2080 schedule is eligible for 480 hours, 2912 schedule is eligible for 672 hours

1. REASON FOR LEAVE

The birth of your child or placement of a child with you for adoption or for foster care

The need to care for spouse, child, or parent who has a serious health condition

My own serious health condition that prohibits me from performing the essential functions of my job.

**You may be subject to a fitness-for-duty physical (to assess your ability to perform the essential functions of your job) before being allowed to return to work.*

To care for a Service Member or Veteran who has been injured in the line of duty

To manage affairs while a service member of the National Guard, Reserves or Armed Forces is on covered active duty in support of a contingency operation

2. HEALTH CARE PROVIDER'S CERTIFICATION

The completed certification form from my physician is attached
I will provide the physician certification form within 15 days
I have provided a certification for Exigency Leave giving specific frequency or duration
N/A – My leave request is for birth/adoption/foster of child and is not required

3. LENGTH OF LEAVE REQUESTED

Start Date: _____ End Date: _____

I am requesting Full-time leave Intermittent leave

-If you are requesting specific dates, times or schedule, please list:

**Employees needing an intermittent/reduced schedule must work with their employer to schedule the leave to not unduly disrupt the employer's operations (subject to the approval of the health care provider.) In such cases the employer may transfer the employee temporarily to an alternative job with equivalent pay and benefits that accommodates recurring periods of leave better than the employee's regular job.*

4. COMPENSATION WHILE ON LEAVE

While on FMLA leave I choose to use the following accruals (number the leaves to be used in priority order and the number of hours to be used

<u>Priority Order</u>	<u>Type of Leave</u>	<u>Number of Hours to be Used</u>
_____	Sick	_____
_____	Vacation	_____
_____	Comp Time	_____
_____	Floating Holiday	_____
_____	Holiday	_____
_____	PTO	_____
_____	Parental Leave	_____
_____	Sick Industrial	_____
_____	Leave Without Pay	_____
_____	Donated Leave*	_____
_____	Other	_____

Type of Leave: _____

*Donated Leave may only be used after all other leaves have been exhausted and required a request form

5. INSURANCE BENEFITS

-While on paid leave, benefit costs will continue to come out of your paycheck.

-While on unpaid leave under FMLA, you will need to contact Payroll at 213-2200 to make arrangements to directly pay for your benefits

This includes employee only benefits and dependent benefit coverage and all types of coverage (health, voluntary life insurance and disability)

<p align="center">Employee Acknowledgment</p>
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By signing below, I certify that I have read the City of Flagstaff Family and Medical Leave of Absence Policy 1-50-050 and that I agree to abide by the requirements of the Policy.

Employee Signature: _____ Date: _____