Revised 08/13/2012

# CITY OF HOLYOKE
## Employee Family & Medical Leave Request Form
## (Family & Medical Leave Act of 1993)

**Employee's Name: _____** **Date: _____**
**Job Title: _____**
**Immediate Supervisor: _____**
**Social Security Number: _____**

**Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to up to twelve (12) weeks of unpaid, job-protected leave for certain family and medical reasons. Submit this request form to your supervisor at least thirty (30) days before the leave is to commence, when practicable. When submission of the request thirty (30) days in advance is not practicable, submit the request as early as is practicable. The employer reserves the right to deny or postpone leave for failure to give appropriate notice when such denial/postponement would be permitted under federal or state law.**

## ELIGIBILITY

1. Counting any periods of time that you worked for the City of Holyoke (whether they were consecutive or not), have you worked for the City for a total of twelve (12) months or more?
( ) Yes ( ) No
(If "yes," continue to the next question. If "no," stop here.)

2. During the past twelve (12) months, have you worked at least 1,250 hours?
(Approximately eight (8) months of 40-hour weeks or one year of 25-hour weeks)
( ) Yes ( ) No
(If "yes," continue to the next question. If "no," stop here.)

3. Have you previously received FMLA?
( ) Yes ( ) No
If yes, provide information below:
Dates of leave:From_____ to _____

Purpose of leave: _____
_____
_____

4. Have you taken any intermittent leave? ( ) Yes ( ) No

5. Have you taken time off from scheduled hours? ( ) Yes ( ) No

If "yes," provide details: _____
_____
_____

## REASONS FOR REQUESTING LEAVE

Leave must be granted for any of the following reasons:

- For a serious health condition that makes it unable for you to perform your job;
- To care for your child, spouse, or parent who has a serious health condition; or
- To care for your child after birth, or for placement after adoption or foster care.

**I am requesting leave for the following reason(s)**:

( ) Personal serious health condition
( ) Serious health condition of:

Spouse Name: _____
Child Name: _____
Parent Name: _____

( ) Birth of a child Expected delivery date: _____

( ) Adoption or placement of a child for foster care

Childs Name: _____
Scheduled date of adoption or placement: _____

## DATES OF LEAVE REQUESTED

I request leave from _____to _____

I request intermittent leave according to the following schedule:
_____
_____
_____

I request a reduced schedule leave according to the following schedule:
_____
_____
_____

The total number of days of leave that I am requesting: _____

## EMPLOYEE STATEMENT:

I agree to return to work on _____. If circumstances change such that I will not be able to return to work on this date, I agree to inform my immediate supervisor by submitting a NOTICE TO EMPLOYER OF CHANGES IN APPROVED MEDICAL OR FAMILY LEAVE form. *I understand that my benefits will continue during my leave and that I will arrange to pay my share of applicable premiums.*

Signature: _____ Date: _____