Department of Transformation and Shared Services
Office of Personnel Management

Request for Family and Medical Leave (FMLA)

Department/Agency Name			Date
Employee Name *(Last, First, Middle)*			Begin FMLA Date
Personnel Number	Business Area	Personnel Area	End FMLA Date
Organization Unit	Job Title		Phone

I understand that FMLA, as federally mandated, is unpaid leave. FMLA will run concurrently with any paid leave, including Catastrophic Leave.

I understand that my employer may require a written second opinion from a health care provider at the expense of the agency.

I understand that during FMLA, the agency will continue paying the Employer portion of my group Health Plan, if I am a participant. I understand that during any unpaid FMLA, I am responsible for paying the Employee's portion for the Health Plan for each pay period. If I do not pay, my Health Plan may be canceled after 30 days.

After I have been given the opportunity to cure any deficiencies, I understand that my employer may have a health care professional, human resources professional, leave administrator or management official contact my Health Care Provider for clarification/authentication of my medical certification.

☐ Yes ☐ No I am requesting FMLA for the days shown above.

☐ Yes ☐ No I am requesting FMLA to run concurrently with maternity leave. (If maternity leave is paid as part of the catastrophic leave program)

☐ Yes ☐ No I am requesting my accrued leave (paid leave) be substituted for unpaid leave. I will submit my request for paid leave in accordance with the agency's process for submitting leave.

Date to begin paid leave	Date to end paid leave

Employee's Signature	Date

ACKNOWLEDGEMENT:

Manager's Signature	Date
Administrator's/Division Director's Signature	Date
HR Official's Signature	Date