



FMLA REQUEST FORM

Employee Name (printed) _____

Program _____

Date Submitting This Form _____

I am notifying the LABBB Collaborative of my need to take family/medical leave due to:

- 1.) ___ The birth of a child, or the placement of a child with me for adoption or foster care; or
- 2.) ___ A serious health condition that makes me unable to perform the essential functions of my job; or
- 3.) ___ A serious health condition affecting my ___ spouse, ___ child, ___ parent, for which I am needed to provide care.

I am notifying you that this leave will begin on _____ (date) and that I expect leave to continue until, on or about _____ (date).

1a.) ___ If my maternity/medical leave extends beyond eight consecutive weeks I understand that I will be required to provide a doctor's note stating the specific date I can return to work.

1b.) ___ I would like to apply _____ of my accumulated sick days towards my maternity/medical leave.

I understand that failure to return to work at the end of the leave period (12 weeks) may be treated as a resignation unless an extension of leave has been agreed upon and approved by the employer.

Employee Signature Date

Executive Director Signature Date