



# FMLA EMPLOYEE LEAVE REQUEST FORM

Employee Name: \_\_\_\_\_ Position: \_\_\_\_\_

Date of Request: \_\_\_\_\_

## Request for Consecutive Leave:

I request a leave of absence from \_\_\_\_\_ (date) to \_\_\_\_\_ (date) for the following reason:

\_\_\_\_\_ For the birth of my child and/or to care for the newborn child.

\_\_\_\_\_ For placement of a child with me for adoption or foster care.

\_\_\_\_\_ To care for my (circle one): spouse, child, or parent with a serious health condition.

\_\_\_\_\_ Because of my own serious health condition.

\_\_\_\_\_ Because of military active duty call up for spouse, son, daughter, or parent.

\_\_\_\_\_ To care for an injured military spouse, son, daughter, parent or next of kin.

## Request for Intermittent or Reduced-Schedule Leave:

\_\_\_\_\_ I request intermittent leave or reduced-schedule leave for the following times:

Schedule: \_\_\_\_\_

Reason: \_\_\_\_\_

## Contact Information:

I can be reached at the following address, phone number or email during my approved FMLA leave:

\_\_\_\_\_

Employees must have worked for HIT, Inc. For 12 months and have worked 1,250 hours to qualify for FMLA leave. If HIT, Inc. requests a medical certification, you have 15 calendar days to provide it in most circumstances. Employees are responsible for the cost of getting the certification from a health care provider. If an employee fails to provide the requested medical certification, the FMLA request may be denied. If an employee exhausts their FMLA leave entitlement and is unable to return to work, Hit, Inc. is not required by law to restore you to your current position.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date