



REQUEST FOR FMLA AND/OR TEMPORARY EXPANDED SICK LEAVE

Under the Family and Medical Leave Act (FMLA) eligible employees are entitled to take up to 12, or in certain instances 26, weeks of job-protected leave for their own or an immediate family member's significant health need. Please submit this completed and signed request form to the Office of Human Resources 30 days before the leave is to begin, or as soon as possible if less than 30 days' notice is known. Your eligibility under FMLA will be determined and you will be notified. For those meeting eligibility, additional FMLA forms will be emailed to you as soon as administratively possible.

See additional information on the [HR FMLA webpage](#).

The Temporary Expanded Sick Leave Policy can be found [here](#).

Employee Information

Employee Last Name	Employee First Name	Employee Job Title
Employee Department	Supervisor's Name	Today's Date

Duration of Leave

Leave expected to begin: _____ Leave expected to end: _____
 Please summarize reason for leave and if intermittent or reduced-leave schedule is being requested, please explain why it is needed and the proposed leave schedule.

Reason for Leave

I am requesting standard FMLA leave for the following reason:	
<input type="checkbox"/>	My own serious health condition
<input type="checkbox"/>	Birth of my child; care for my newborn (both parents are eligible)
<input type="checkbox"/>	Placement of child with me for Adoption or Foster Care
<input type="checkbox"/>	To care for child/spouse/parent with a serious health condition Family member's name _____ Family member's relationship: _____
<input type="checkbox"/>	Qualifying exigency because a family member is on or has been called to covered active duty in the Regular Armed Forces (including the National Guard and Reserves) to a foreign country
I am requesting Expanded Sick Leave for the following reason (may run concurrent with FMLA):	
<input type="checkbox"/>	To care for a dependent child whose school or child care facility/provider is closed or unavailable for reasons related to COVID-19
<input type="checkbox"/>	To be a full-time caregiver for my spouse, child, or parent with a COVID-19 related illness
<input type="checkbox"/>	For my own required quarantine or isolation due to COVID-19

EMPLOYEE SIGNATURE: _____ DATE: _____

RECEIVED BY: _____ DATE RECEIVED: _____