Family and Medical Leave Request Form

Employee: _____ Date of Hire: _____

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons. Submit this request form to your supervisor at least 30 days before the leave is to commence, when practical. When submission of the request 30 days in advance is not practical, submit the request as early as possible. 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 law.

ELIGIBILITY

1. Counting any periods of time that you worked for the Tribe (whether they were consecutive or not) have you worked for the Tribe for a total of 12 months or more? ☐ Yes ☐ No
   (If "yes," continue to next question. If "no", stop here.)
2. During the past 12 months, have you worked at least 1,250 hours? (approximately eight months of 40-hour weeks or one year of 25-hour weeks)? ☐ Yes ☐ No
   (If "yes," continue to next question. If "no", stop here.)
3. Have you previously received medical or family leave? If yes, provide information below: ☐ Yes ☐ No

   Dates of leave: From _____ To _____

   Purpose of leave: _____
4. Have you taken any intermittent leave? If "yes", provide details ☐ Yes ☐ No

   _____

   _____

REASON FOR REQUESTING LEAVE:

Leave must be granted for any of the following reasons:

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

I am requesting leave for the following reason:

☐ Birth of a child Expected delivery date: _____

☐ Adoption or placement of a child for foster care. Child's name: _____

Scheduled date of adoption or placement: _____

☐ Serious health condition of:

spouse Name: _____

child Name: _____

parent Name: _____

☐ Personal serious health condition

If Personal or Family (spouse, child, parent) Serious Health Condition provide the following:

Physician's Name: _____

Address: _____ Phone: _____

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:

_____

_____

EMPLOYEE STATEMENT

I understand that the Health Care Provider must certify a leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child, or parent.

I hereby authorize the Walker River Paiute Tribe to contact my physician to verify the reason for my requested leave or for any other information concerning my requested family and medical leave.

I agree to return to work on _____. If circumstances change such that I will not be able to return to work on that date, I agree to inform my supervisor and the Human Resources department.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing. I understand that my health insurance coverage will continue during my leave and that I will arrange to pay my share of applicable premiums. I will reimburse the Walker River Paiute Tribe for the total costs of health insurance premiums paid on my behalf if I fail to return to work from approved Family Medical Leave.

_____ _____

Signature Date

TO BE COMPLETED BY SUPERVISOR AND HUMAN RESOURCES

Employee date of hire: _____ and is ☐ Full-time ☐ Part-time

Regular hours are: _____ hours on _____ days of the week for a total of _____hours per week.

Has the employee worked for at least one year, and 1,250 hours in the previous 12 months? ☐ Yes ☐ No

Are there 50 or more staff members at or within 75 miles of the worksite where the staff member works? ☐ Yes ☐ No

Has the workforce been this large for at least twelve (12) months? ☐ Yes ☐ No

Employee has previously requested family or medical leave on: _____

Leave taken from _____to _____ Total time taken: _____

Leave is: ☐ Approved

☐ Denied for the following reason(s): _____

_____

_____

Request approved/denied by: _____ Date: _____

Supervisor

_____ Date: _____

Human Resources Representative

06/02