LEAVE REQUEST FOR:

FAMILY and MEDICAL LEAVE (FML) _____ **Washington Family Care (WFC) _____**

- *All WFC leave requests must be accompanied with doctor's certification or documentation from your child's school or daycare indicating your child was absent.*
- *All FMLA leave requests must be accompanied with medical certification from a health care provider.*

_____ _____/_____
Employee's Name Phone # Today's Date Return Form by

_____ _____
Address Department

_____ _____
City State Zip Date of Hire E-mail Address

Date on Which Leave Will/Did Begin _____

Date You Expect to Return to Work _____

Reason for Leave

_____ Prenatal Maternity Leave
_____ Birth of Child
_____ Care of Newborn Infant (within 12 months following birth)
_____ Adoption or Foster Care of Child (within 12 months of placement)
_____ Serious Health Condition of:

_____ Employee (Only FML) _____ Spouse
_____ Son _____ Daughter
_____ Parent _____ Parent-in-law (Only WFC)
_____ Grandparent (Only WFC)

Please describe the serious health condition that necessitates this leave request.

_____

_____

Type of Leave Requested

_____ Consecutive Leave _____ Intermittent or Reduced Work Schedule

Comments:_____

Paid or Unpaid Leave

Please indicate the number of <u>hours</u>, <u>days</u> or <u>weeks</u> of each type of leave you wish to use. An employee may retain up to forty hours of available paid sick and vacation leave for future use prior to taking unpaid leave.

I wish to use _____ of my <u>earned sick leave</u>.

I wish to use _____ of my <u>earned vacation leave</u>.

I wish to take _____ of <u>unpaid leave (only for approved FML)</u>.

I wish to use _____ <u>floating holiday(s)</u>.

I wish to use my <u>birthday holiday</u>. Yes _____ No _____

_____ _____
Employee Signature Date

If you have any questions about your leave request, please contact the Human Resources Department.