SPOKANE TRANSIT EMPLOYEE LEAVE REQUEST FORM

FAMILY and MEDICAL LEAVE (FMLA) _____ **WASHINGTON FAMILY CARE (WFC) _____**

- All FMLA leave requests will require medical certification completed by a health care provider.
- All WFC leave requests will require a doctor's certification completed the provider, or documentation from your child's school or daycare indicating your child was absent.

_____ _____
Employee's Name Phone #

_____
Address City State Zip

_____
Department Mail Box # if applicable

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.

_____

☐ **Check box if this request is because of a work related incident**

Type of Leave Requested _____ Consecutive Leave _____Intermittent or Reduced Work Schedule

Paid or Unpaid Leave: According to STA policy employees are required to use paid leave prior to taking unpaid leave. Please indicate the number of hours, days or weeks of each type of leave you wish to use. You may retain up to forty hours of available paid sick and vacation leave for future use.

I wish to use _____hours earned sick leave. Please retain _____hours of my earned sick leave (40 max).

I wish to use _____hours earned vacation leave. Please retain _____hours of my earned vacation leave (40 max).

I wish to take _____hours unpaid leave (only for approved FML).

I wish to use _____ floating holiday(s). I wish to use my birthday holiday. Yes _____ No _____

I understand the FMLA medical certification form is a federal document and that Section II of the form must be completed by a health care provider or their designated office staff, and signed by the health care provider. By signing this form I affirm that Section II of the FMLA forms and any other documents submitted were completed by a health care provider or their authorized office staff. I attest that the information I provided regarding my request for leave is correct and true.

_____ _____
Employee Signature Date