441 White Pine Dr. | Laurel Park, NC 28739 | www.laurelpark.org | office: 828-693-4840

Application for Family or Medical Leave (FMLA)

The Town will grant up to 12 weeks of family and medical leave per twelve months (rolling year) to eligible employees in accordance with the Family and Medical Leave Act of 1993 (FMLA).

To qualify for FMLA coverage, the employee must have worked for the employer 12 months or 52 weeks; these do not have to be consecutive. However, the employee must have worked 1,250 hours during the twelve-month period immediately before the date when the FMLA time begins.

Name of Employee: _____

Date of Hire: _____ Start Date of Leave: _____ Expected End Date: _____

Hours per week Requested: _____ Specify your schedule if less than full-time leave is required: _____

Personal phone number and/or email: _____

Supervisor's Name: _____ Department: _____

Leave is for: _____ Personal Illness _____ Adoption _____ Birth of a Child_____ Military Exigency

_____ Family Member Illness (spouse, child/parent)

Have you been absent from work (paid or unpaid) for an FMLA eligible leave during the last 12 months? _____

The leave may be paid (coordinated with the Town's Vacation, Sick, and Compensatory Leave policies), unpaid, or a combination of paid and unpaid. Unpaid leave will be granted only when the employee has exhausted all appropriate types of paid leave. Additional time away from the job beyond the 12-week period may be approved in accordance with *Town Policy 600.04, Leave of Absence Without Pay.*

I will exhaust two weeks of paid _____(sick/vacation/combination) leave, then anticipate to use _____(number) week(s) of paid family leave offered by the Town (up to six (6) weeks of paid family medical leave). For a total of _____ weeks of leave.

I agree to return to work on _____. If circumstances change such that I will not be able to return to work on the indicated date, I agree to inform my supervisor. I understand that my benefits will continue during my leave and that I will arrange to pay my share of applicable premiums.

Employee's Signature _____ Date: _____

This application must be accompanied by medical documentation from the patient's physician, or other supporting documentation as appropriate.

HUMAN RESOURCES SECTION:

Leave is: _____ Approved _____ Denied for the following reason(s) _____

Request is approved/denied by: _____ Date: _____