425 Huehl Rd, Bldg 13 Suite B Northbrook, IL 60062
Tel 224-636-5200 Fax 224-636-5210

FMLA Notice/Leave of Absence Request

(Please read carefully, very important document)

Family and Medical Leave Act (FMLA) is a Federal law that grants eligible employees the right to take unpaid leave if it has been earned and is available, for a period of up to 12 weeks. Employees are eligible if they have worked for the employer for at least one year, for 1,250 hours over the previous 12 months.

Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313.

Upon return from FMLA leave, Employees will be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Employees wishing to return to work following an authorized leave of absence must provide the Company with thirty (30) days advance notice <u>in writing</u> of a desire to return to work. Any employee who fails to return to work on their return date may be subject to discipline action and/or discharge.

All leaves of absence must be approved in advance. This form must be completed and returned to the Human Resources office when you request your leave. A leave of absence is not considered official until the Department head gives final approval.

NAME: _____ DATE: _____

DEPARTMENT: _____

TITLE: _____ DATE OF HIRE: _____

SUPERVISOR or DEPT. HEAD: _____

<u>TYPE OF LEAVE REQUESTED</u>

_____ **Medical Leave – Employee's Own Serious Health Condition**

FMLA is limited to serious medical conditionals and is not to be substituted for sick days. A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities. Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

If this is a medical leave for yourself, you will be eligible for leave for a period of no more than six months (short term disability) until you have been released to return to work.

Start date of Leave: _____ Return date from Leave: _____

Reason for Medical Leave: _____

(**Medical Certification for <u>MUST</u> be completed by medical care provider and attached to the form.)**

_____ **Family/Special Leave – to care for a family member/service member**

If leave is required to care for a family member, this leave will be granted in accordance with the Family and Medical Leave Act of 1993, and will not be granted for longer than 12 week in any one year period. State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule

(please attach the schedule to form)

Special Leave Entitlement

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list

Start date of Leave: _____ Return date from Leave: _____

Relationship of employee to family member/service member: _____

Health condition of family member/service member: _____

Care you will provide: _____

If a minor child, indicate age: _____

_____ **Pregnancy Leave**

If requesting leave for pregnancy, you will be eligible for leave for a reasonable period of time. However, this leave will be granted in accordance with the Family and Medical Leave Act of 1993, and will not be granted for longer than 12 weeks in any one year period.

(Medical Certification form <u>MUST</u> be completed by Genecology Specialist and attached to the form.)

Start date of Leave: _____ Return date from Leave: _____

_____ **Parental Leave**

If requesting parental leave for the care of a newborn, newly adopted child, or to assume guardianship of a child, this leave will be granted in accordance with the Family and Medical Leave Act of 1993, and will not be granted for longer than 12 weeks in any one year period.

Start date of Leave: _____ Return date from Leave: _____

Anticipated birth date of the newborn: _____

Anticipated arrival date of the newly adopted child: _____

Anticipated arrival date of the child for whom I will be a guardian: _____

_____ **Military Leave**

Start date of Leave: _____ Return date from Leave: _____

_____ **Personal Leave (not to exceed five (5) business days per calendar year inside of the U.S.A. and up to twenty-eight (28) days when you travel outside of the U.S.A.)**

Start date of Leave: _____ Return date from Leave: _____

DATE LEAVE ACTUALLY STARTED: _____

Employees must keep in contact with their department on a regular basis to let the department know your status and your intent to return to work. Failure to return from Leave of Absence on the agreed upon date will result in termination for job abandonment.

Employee Signature _____ Date _____

Supervisor Signature _____Date _____

HR Manager Signature _____ Date _____