COCONINO COUNTY
REQUEST FOR
FAMILY OR MEDICAL LEAVE OF ABSENCE

Employee ID Number _____

When the need for a leave of absence is foreseeable, you are required to request the leave 30 days in advance. Examples of foreseeable events include planned medical treatment or your child's birth. For unforeseen events, such as accidental injury causing a serious health condition, premature birth, or sudden change in your health, you are required to request the leave as soon as it is possible and practical to do so. The County's Family and Medical Leave of Absence Policy contains an explanation of your rights and obligations regarding leaves of absence under the County's Policy and the FMLA.

Name: _____

Address: _____
Street / PO Box City State Zip Code

Home Phone: _____ Today's Date: _____

Department: _____ Position: _____

Supervisor: _____ Date of Hire: _____

The reason you are requesting a leave of absence is (check the appropriate line):

☐ the birth of your son or daughter or the placement of a son or daughter with you for adoption or for foster care (NEW CHILD LEAVE);

☐ the need to care for your spouse, son, daughter, or parent who has a serious health condition (FAMILY MEDICAL LEAVE); or

☐ your own serious health condition that prohibits you from performing essential function(s) of your employment position (EMPLOYEE MEDICAL LEAVE).

Have you taken a leave of absence under this Policy during the past twelve months?

☐ Yes ☐ No

If yes, when was the last such leave? From: _____ To: _____

If your spouse works for the County, has your spouse taken a leave of absence under this Policy during the past twelve months?

☐ Yes ☐ No ☐ Not Applicable

If yes, when was the last such leave? From: _____ To: _____

If you are requesting a **NEW CHILD LEAVE**, please answer the following questions:

1. Requested Leave Time:

   From: _____ To: _____

2. What is the ☐ anticipated or ☐ actual date of birth or placement?

   _____

If you are requesting a **FAMILY MEDICAL LEAVE** or **EMPLOYEE MEDICAL LEAVE,** please answer the following questions:

1. Have you submitted the necessary Medical Certification with this form?
   ☐ Yes ☐ No
2. Are you requesting *full-time* leave?
   ☐ Yes ☐ No
   If you are requesting full-time leave, please answer the following questions:
   Requested leave time:

   From: _____ To:_____
   What other dates would be appropriate for the leave:

   _____
3. Are you requesting ***intermittent*** or *reduced schedule* leave?
   ☐ Yes ☐ No
   If yes, please answer the following questions:

Why is it medically necessary for you to have intermittent or reduced schedule leave?

For which dates, times, or schedules are you requesting leave?

What other dates, times, schedules would be appropriate for your intermittent or reduced schedule leave:

By signing below, you are certifying that you have read the attached County's Family and Medical Leave of Absence Policy and that you agree to abide by the requirements of the policy. Failure to abide by these requirements may result in delay or denial of your leave. By signing, you also affirm that you have been and will be truthful and sincere in your request for a leave of absence.

_____ _____
Employee Signature Date

_____ _____
Department Director Acknowledgement* Date
*approval is made by Human Resources/Risk Management

Human Resources Use Only

Received by: _____ Date: _____

Length of Employment at least 12 months: ☐ Yes ☐ No

Regular Hours Worked at least 1,250 hours: ☐ Yes ☐ No

Amount of FMLA Leave used during the past twelve months? _____

Date Range: _____/_____/_____ - _____/_____/_____

Approved _____ Denied _____ Pending _____