

## Delaware County Family Medical Leave Request Form

*When requesting Family Medical Leave, employees are required to provide thirty days written notice or, if this is not possible, as much notice as is practical. An employee undergoing planned treatment is required to make a reasonable effort to schedule the treatment to minimize disruptions to operations.*

### Employee Information

Employee Name: \_\_\_\_\_

Job Title: \_\_\_\_\_ Department: \_\_\_\_\_

Department Head: \_\_\_\_\_

Date Submitted: \_\_\_\_\_

### Leave Request Information

I am requesting leave under the Family Medical Leave Act. I require a leave of absence because:

- ☐ I am temporarily unable to work because of my own serious health condition.
- ☐ I will be caring for a \_\_\_ spouse, \_\_\_ child or \_\_\_ parent with a serious health condition.  
Birth and care of a newborn child; the placement of a child for adoption or foster care and to care for
- ☐ the newly placed child.
- ☐ I will be caring for the serious injury or illness of a covered military service member.

Beginning Leave Date: \_\_\_\_\_

Expected Return Date: \_\_\_\_\_

It is my understanding that I am eligible for up to twelve weeks of unpaid leave under the Family Medical Leave Act. I understand to be eligible for FML leave; I must have been employed by Delaware County for a least one year and have worked 1,250 hours within the previous twelve month period. I understand I must be returned either to the same position I was in prior to the leave or to a position equivalent in pay, benefits, and other terms and conditions of employment.

I understand, as stated in the Employee Policy Handbook, I must use any accrued paid leave (such as sick leave, compensatory time, personal days, and vacation days) for any part of the twelve-week period of such leave. I also understand I may elect to reserve use of up to five vacation days.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date