THE CITY OF PORTSMOUTH

REQUEST FOR FAMILY AND MEDICAL LEAVE FORM

Employee Name_____ Title_____
Department_____ Date_____/_____/_____

You may have qualified for FMLA. Currently, you have _____ weeks of FMLA available during this calendar year. You are required to use all paid sick and annual leave before requesting unpaid leave. Your current combined accrued leave balance is:_____

Please complete the questions below and provide medical certification, if required. **If medical certification is required (see below), please return the Medical Certification forms to the Bon Secours MedCare Center for review within 15 days.** If no medical certification is required, please return this form directly to your department within 15 days. Your department will notify you if you qualify under FMLA.

***IMPORTANT NOTICE ON GENETIC INFORMATION NONDISCRIMINATION ACT (GINA):**
Employees should **not** provide genetic information to the City of Portsmouth, including family history, unless a GINA exception applies, such as the FMLA Exception for seriously ill family members. Please refer to the City's Administrative Policy (AP) #24 on GINA for further details.

To be Completed by Employee:
I am:
- ❑ Requesting Family/Medical Leave
- ❑ Requesting Intermittent Family/Medical Leave (only for serious health condition of self, spouse, parent, child)
- ❑ Requesting ***Military*** Family/Medical Leave
- ❑ Requesting Intermittent ***Military*** Family/Medical Leave

Reason for Leave (please check only one):
- ❑ Birth, adoption, or foster placement of a child
- ❑ Serious health condition of a spouse, parent, or child ***(Medical certification form required)*
- ❑ Serious health condition of employee ***(Medical certification form required)*
- ❑ ***Military*** – Serious health condition of covered service member or veteran ***(Medical certification form required)*
- ❑ ***Military*** – Caregiver for serious health condition of covered service member or veteran ***(Medical certification form required)*
- ❑ ***Military*** – Qualifying exigency ***(Certification form and military documentation required)*

Date Leave to Begin_____ Date Leave to End_____

Employee's Signature_____ Date____/____/____

To be Completed by Bon Secours MedCare Center:
Date Medical Certification form received: _____/_____/_____

Date Certified by Physician: Date Leave to Begin: _____ Date Leave to End: _____

Condition qualifies for FMLA: _____Yes _____No ******SEND FORM BACK TO HUMAN RESOURCES***

Signature of City's Health Care Provider_____ Date: ____/____/____

To be Completed by Department Head or Designee:
Is the employee eligible for FMLA? (Employed for at least 12 months and worked 1,250 hours in the 12 months prior to the request for leave) _____Yes _____No

Dates:
Request for Leave Given/Sent: _____ Request for Leave Received Completed: _____
Employer Response Sent: _____ Number of Weeks Applied to FMLA: _____

_____ _____
Signature of Department Head or Designee Date

Cc: Human Resource Management

Revised May 2013