CITY OF CLARKSVILLE
REQUEST FOR FAMILY AND MEDICAL LEAVE

EMPLOYEE INFORMATION

1. Name: **Social Security:**	**2. Title:** **Department:**

3. Reason for requesting leave:

a. ☐ Birth of a child

b. ☐ Active Duty Leave to employee whose spouse, child or parent is called to active duty

c. ☐ Placement of a son or daughter for adoption/foster care.

d. ☐ Care for child, spouse, parent, or legal dependent with a serious health condition (be sure to answer #4 and #5)

e. ☐ Serious health condition which makes me unable to perform the functions of my position

f. ☐ Caregiver Leave of up to 26 weeks for a spouse, child, parent or nearest blood relative to care for a recovering service member.

4. If 3d is checked, please indicate: ☐ Child ☐ Parent ☐ Spouse ☐ Legal Dependent

5. Name and Address of Family Member: ____

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6. Effective Date of Leave Request:	**7. Date of anticipated return to work:**

8. Are you requesting leave on an intermittent or reduced work schedule? ☐ Yes* ☐ No

*If yes, please provide a certification from a health care provider justifying the necessity for intermittent leave. On a separate sheet give a schedule of when you anticipate you will be unavailable for work.

9. I understand that sick, vacation and sick leave transfer leave, and leave without pay will all count towards my 12 weeks of leave

Employees seeking leave because of Reason 3d or 3e *must* have a health care provider complete the Certification of Health Care Provider Form and return it to their personnel office within 15 days, or as soon as practicable. Leave may be delayed until a completed form is provided. Employees seeking to return to work after a leave because of Reason 3e, ***also*** must complete the Return to Work Medical Certification Form before they will be allowed to resume work. Employees may not be permitted to resume any position until a completed Return to Work Medical Certification Form is provided.

EMPLOYEE AGREEMENT

If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired, or that I am needed to care for a covered relative because he/she has a serious health condition on the date that my leave expired. I understand that while on FMLA leave, I will contact the Personnel Officer of my agency after I have been on leave for 30 calendar days and at the end of each 30-day period afterwards.

Signed:____**Date:** ______________________