REQUEST* FOR FAMILY MEDICAL LEAVE OF ABSENCE (FMLA)

Employee Name _____ Employee # _____ Job Title _____

DOH _____ Is this your first time requesting FMLA ☐ Yes ☐ No, date of last request _____

Mailing Address _____ City_____ State___ Zip_____

Phone #_____ Email Address _____

Department: _____ Dept. #: _____ Dept. Director: _____

Department Contact Person _____ Phone # _____
First and Last Name

Supervisor Name _____ Phone # _____
First and Last Name

Reason for FMLA Leave:

☐ Employee Serious Injury / Illness ☐ Qualifying Exigency (Military Only)

☐ Care for Immediate Family Member ☐ Maternity Leave (Birth Mother) _____

☐ Birth, Placement, Adoption, Foster Care or Bond with newborn/newly placed child

Are you in the sick leave pool ☐ Yes ☐ No
Sick Leave Pool Applies **ONLY** When an Employee has a Serious Injury / Illness

Note: You must use any sick and vacation leave you have available while on FMLA.

Dates of Leave	**Start date:**	**Return date:**

Employee Signature: _____ Date: _____

EMAIL COMPLETED FORM TO HR: BENEFITS@AUGUSTAGA.GOV

or bring to HR at 535 Telfair Street Suite 400 of 4th Floor of Municipal Building.

*NOTE: submittal of this request **is not an approval**. Coordination between you, your health care provider and HR liaison is crucial for a timely approval. After notification that an employee has requested leave:

1. HR liaison will provide written notice of your FMLA eligibility, rights & responsibilities **within five (5) business days of receipt**.
2. Written notice of FMLA approval or denial will be provided **upon receipt of all required documentation/certification.**

Employees are responsible for managing the FMLA documentation process. Submittal of required documentation to HR is the sole responsibility of the employee, and failure to do so will result in denial of your FMLA request.

HUMAN RESOURCES USE ONLY:

Accrued Leave Balance at time of leave:

Sick Leave Balance _____Vacation Balance_____Other, specify_____

FMLA Designated: Yes ☐ No ☐ Days Used: _____ Intermittent leave? Yes ☐ or No ☐

Sick Pool Participant: Yes ☐ No ☐ Returned Date: _____

Reason Denied_____