# CITY OF MISSION
## Employee Request for Family and Medical Leave

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| 1. Employee Name:<br>Address:<br><br>Phone Number:<br><br>S.S. # | 2. Employee's Job Title:<br><br>Work Schedule:<br><br><br>Department/Division: |

3. Reason for requested leave:

a. [ ] The birth of a child, or placement of a child with you for adoption or foster care;
b. [ ] Your own serious health condition;
c. [ ] Because you are needed to care for your ___ spouse; ___ child; ___ parent due to his/her serious health condition
d. [ ] Because of a qualifying exigency arising out of the fact that your ___ spouse; ___ son or daughter; ___ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
e. [ ] Because you are the ___ spouse; ___ son or daughter; ___ parent; ___ next of kin of a covered servicemember with a serious injury or illness.

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| 4. Date on which you wish to commence leave. | 5. Date of anticipated return to work. |
| 6. On what basis are you requesting leave?<br><br>[ ] Full time [ ] Intermittent | 7. If "Intermittent", please give schedule of when you anticipate you will be unavailable to work. |

**Employees seeking leave must provide medical certification within 15 days or as soon as practicable. Once we obtain the information from you, we will inform you, within five (5) business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement.**

**Employees seeking to return to work after a leave because of their own serious health condition [reason "3 b"], must also provide a medical certification of ability to perform job duties before they are allowed to return-to-work.**

I hereby understand that if my leave qualifies as FMLA leave I have the following rights while on FMLA leave: 1.) I have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as the calendar year (January – December). 2.) I have the right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. 3.) My health benefits must be maintained during any period of unpaid leave under the same conditions as if I continued to work. I agree that while I am on leave, I will continue to pay my share of health insurance premiums under the same conditions as if I continued to work. 4.) I must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on my return from FMLA-protected leave. If my leave extends beyond the end of my FMLA entitlement, I do not have return rights under FMLA. 5.) If I do not return to work following FMLA leave for a reason other than: a.) the continuation, recurrence, or onset of a serious health condition which would entitle me to FMLA leave; b.) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle me to FMLA leave; or c.) other circumstances beyond my control, I may be required to reimburse the City of Mission for our share of health insurance premiums paid on your behalf during your FMLA leave. 6.) I must use accrued paid leave while taking my unpaid FMLA leave entitlement. I have the right to have sick, vacation and/or other leave run concurrently with my unpaid leave entitlement, provided I meet any applicable requirements of the leave policy. If I do not meet the requirements for taking paid leave, I remain entitled to take unpaid FMLA leave.

While on leave I will furnish the City of Mission Human Resources department periodic reports of my status and intent to return to work every fifteen (15) days. 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 meet the functions of my position on the date that my leave expired or that I am needed to care for my spouse/parent/child because he/she has a serious health condition on the date that my leave expired. I understand that I may not be permitted to resume my position with the City of Mission, until I provide medical certification, as appropriate.

Employee Signature: Date: