Family and Medical Leave Request Form

Employee: Complete this form and forward to Human Resources a minimum of 30 days prior to leave begin date (complete as soon as possible for unplanned leave); obtain required Certification paperwork from HR and return within 15 days of receipt.

Human Resources: Employee, supervisor and department payroll rep will be notified of leave/FMLA approval status after review of request and receipt of Certification. Contact Human Resources at 970-498-5970 with any questions pertaining to family or medical leave, FMLA, or this form.

The Family and Medical Leave Act (FMLA) entitles eligible employees to take unpaid, job protected leave up to 12 workweeks for specified family and medical reasons, (up to 26 workweeks for military caregiver leave) in a single 12-month period. Employees must have worked for the County for at least 12-months (does not have to be consecutive),and must have worked at least 1,250 hours within the preceding 12-months of the start date of leave. Eligible spouses who both work for the County are limited to a combined total of 12 workweeks of leave in a 12-month period for birth and bonding with a newborn, adoption or placement of a child.

EMPLOYEE SECTION

Employee Name: _____

UltiPro Employee #: _____ Department: _____

Email: _____ I agree to receive correspondence electronically ☐ Yes

☐ No (provide mailing address) _____

LEAVE DETAILS

☐ NEW REQUEST

☐ EXTENSION

Leave BEGIN Date:

Leave END Date:

Frequency:

☐ CONTINUOUS YOU WILL NOT RETURN TO WORK UNTIL AFTER THE END OF YOUR LEAVE

☐ INTERMITTENT YOU WILL CONTINUE WORKING BUT WILL TAKE DAYS OR PORTIONS OF DAYS OFF

REASON FOR LEAVE: (Required Certification Forms will be sent by HR)

☐ Employee's Serious Health Condition

Is the condition a work-related injury? ☐ *Yes* ☐ *No*

☐ Care for a Family Member with a Serious Health Condition

Relationship to Employee ☐ *Spouse* ☐ *Child* ☐ *Parent*

☐ Birth of a Child ☐ Adoption/Foster Care Placement of Child

Date of Birth / Expected Birth Date or Placement Date: _____

Relationship to Child: ☐ *Mother* ☐ *Father* ☐ *Foster Parent*

Is the employee married to a Larimer County employee: ☐ *Yes* ☐ *No*

If Yes, please provide name of spouse: _____

☐ Military Family Exigency / Military Family Caregiver Leave

Is this for more than 5 work days in one pay period?

☐ Yes ☐ No

If Yes AND you will be taking leave without pay, complete applicable form below

LEAVE WITHOUT PAY-Complete LWOP Notification form- LCHR-20

SICK LEAVE WITHOUT PAY (when all leave balances have been exhausted)- LCHR-14

I understand:

- This form does not substitute for department-level time off request or call-in procedures, which must continue to be followed;
- All required Certification forms must be returned to HR within 15 days of receipt and are required for final leave approval;
- I must continue to pay Benefit premium deductions, if any, while on Family Medical Leave;
- For leave due to my own medical need, documentation clearing me to work must be submitted to HR **PRIOR** to returning to work; and
- I am responsible for notifying Human Resources of any changes to information on this form or the status of my leave. If leave needs to be extended or modified, updated medical information is required.

EMPLOYEE SIGNATURE: **DATE:**

Send completed form(s) to *HR_FMLA@CO.LARIMER.CO.US* or *FAX 970-498-5980* LCHR-49 (Sept 2018)