



Family Medical Leave Act (FMLA) of 1993
Employee Statement

Employee: _____ Employee # : _____

Home Address: _____

Home Phone #: _____ Cell # _____

Application is for: _____ Employee _____ Family Member

Family Member's Name: _____ Relationship: _____

Supervisor's Name: _____ Phone #: _____

Department: _____

Nature of Illness or Injury _____ Work related? _____

If request is pregnancy related, please indicate due date: _____

Expected length of illness or injury: _____

Have you notified your supervisor of this request? _____ When? _____

Attach the Medical Statement from your physician which includes verification of the above statements. If you wish to add additional information, attach a sheet to the application.

Employee's Signature

Date

Employee Leave Management Office Use Only

Date application received: _____

This request has been: ___ Approved ___ Denied/D. Conley notified: _____

Leave Management Case Manager

Date