COUNTY BOARD OF HEALTH

FAMILY AND MEDICAL LEAVE REQUEST FORM

Name of Employee			**Employee ID#**	
Home Address		**City**		**ST**		**ZIP**	
Contact Phone Number				
I request to use family and medical leave from	Begin Date:	End Date:		
Days & Hours currently working:	☐Mon ☐Tues ☐Wed ☐Thurs ☐Fri	Hours: AM	to PM	

Reason for FML Request - **PLEASE CHECK:**

☐ A. Pregnancy/birth of my child.

☐ B. Care of my newborn child.

☐ C. The adoption or foster care of a child, or care of the child after placement with me.

☐ D. A **serious health condition** (as defined in CBOH Family Medical Leave Policy # 03431 which renders me unable to perform my essential job functions.

☐ E. Care of my (*circle one*) child, spouse or parent who has **a serious health condition.**

PLEASE COMPLETE:
FMLA Type: ☐ Continuous ☐ Intermittent

I request to use available leave during the period of absence as follows (please specify a number of hours or write all in the type of leave you are requesting to use:

_____ Hours of annual leave _____ Hours of personal leave _____ Hours of sick leave

I request to charge _____ hours to leave without pay during the period of absence.
Please submit approved leave request form with this form.

RE: Policy #HR-03431 Family and Medical Leave Policy

I acknowledge receipt and understanding of the Family and Medical Leave Policy and the terms and conditions of my Family and Medical Leave. I agree to abide by the policy guidelines as a condition of my employment and my continuing employment with the County Board of Health.

I understand that use of family and medical leave for any combination of circumstances listed above will be limited to a total of twelve (12) work weeks in a year. I also understand that return to my former position or equivalent position with the same pay and grade, benefits and comparable working conditions is contingent upon compliance with the terms of approved family and medical leave.

______________________________ Signature of Employee

______________________________ Date

SUPERVISOR'S RECEIPT

I received this request on ________________. It is being sent to Human Resources/District Personnel Department on ____________

Print Supervisor's Name:_________________________ Signature:___________________________

COUNTY BOARD OF HEALTH
REQUEST FOR APPROVAL OF LEAVE

Employee's Name (Print or Type): ______________________________

This is to request approval of the following leave:

From:			Thru:			Amount of Leave		Type of Leave	Approved (Initials)
Date	Time	☐ am ☐ pm	Date	Time	☐ am ☐ pm	Hrs	: Mins		☐
Date	Time	☐ am ☐ pm	Date	Time	☐ am ☐ pm	Hrs	: Mins		☐
Date	Time	☐ am ☐ pm	Date	Time	☐ am ☐ pm	Hrs	: Mins		☐
Date	Time	☐ am ☐ pm	Date	Time	☐ am ☐ pm	Hrs	: Mins		☐
Date	Time	☐ am ☐ pm	Date	Time	☐ am ☐ pm	Hrs	: Mins		☐

Leave Balance Before Requested Leave:

Annual __________ Sick __________ Personal ______

Leave Codes

AL	Annual Leave	CL	Court Leave*
SL	Sick Leave	LWOP	Leave Without Pay**
ASSL	Annual to Supplement Sick	FLSA	FLSA Compensatory Time
PL	Personal Leave	SCT	State Compensatory Time
FUL	Furlough	FML/A	Family Medical Leave/Annual
BDL	Blood Donation Leave	FML/S	Family Medical Leave/Sick
ML	Military Leave*	FML/P	Family Medical Leave/Personal

* Copy of orders or subpoena must be attached
** Personnel Action Request form must be submitted

REQUESTED BY: **APPROVED BY:**

______________________ Employee's Signature ______________________ Supervisor's Signature

______________________ Date ______________________ Date