APPLICATION FOR FAMILY, MEDICAL or MILITARY LEAVE - Use of Paid Leave Form
(To be completed by Employee)

NAME: (print) _____ID#: _____

WORK LOCATION: _____

Supervisor:_____ (print)

LEAVE REASON:
- ☐ Birth of child(ren) (medical certification attached)
- ☐ Adoption or foster care (court order attached)
- ☐ Serious health condition that makes me unable to perform the essential functions for my position (medical certification attached)
- ☐ Serious health condition affecting my ☐ spouse ☐ child ☐ parent for which I am needed to provide care (medical certification attached)
- ☐ Family member in military – qualifying exigency
- ☐ Family Member in military – serious injury or illness of servicemember

LEAVE PERIOD TO BEGIN ____ / ____ / _____ AND END ON (through) ____ / ____ / _____

LEAVE TYPES REQUESTED: (Merit Rule Sections: 1470, 1633 & 1642 may apply)	Order			
	____	☐ Sick	_____ ☐ hours	☐ days
	____	☐ Compensatory	_____ ☐ hours	☐ days
	____	☐ Annual	_____ ☐ hours	☐ days
	____	☐ Personal	_____ ☐ hours	☐ days
	____	☐ Leave Without Pay	_____ ☐ hours	☐ days

Please specify the order in which leave should be used.

WORK SCHEDULE (intermittent leave use only – expected frequency and/or days of week):

_____

_____

_____

- Leave requests based on a serious health condition must be accompanied by a verifying medical certification from a licensed provider authorized to practice in the state or country in which the services are rendered, on the appropriate *Certification of Health Care Provider* form. (Employee, Family Member or Military)
- Leave requests based on a serious health condition for a family military family member must be documented by a United States or Department of Defense (DOD) authorized health care provider or an authorized DOD representative if the provider is unable to make certain military-related determinations as outlined in the FMLA.
- During periods of leave without pay, I will be responsible for contacting the Health & Benefits Office and paying the employee share of health insurance benefit premiums.
- I must provide a return to work certificate from my provider prior to being restored to employment. Certification must address any work restrictions, indicate whether restrictions are permanent or temporary and the expected date I will return to full duty from the restrictions. My return to work may be delayed until certification is provided. (M-NCPPC form)

Employee SIGNATURE: _____ DATE:____ / ____ / ____

Department Head approval will now be provided on one of the Department of Labor forms.