

Application for Leave Under the Family and Medical Leave Act

1. Name <i>(please print)</i>	2. SEID
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3. Type of request

Regular FMLA *(12-week)*
 Military Related Exigency Provision *(12-week)*
 Military Family FMLA *(26-week)*

4. Position title	5. Series	6. Grade	7. Organization/Function
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8. Reason for request: *(check all that apply)*

a. *(12-week)* Birth of a son or daughter and care of such child. [5 CFR 630.1203a(l)]

b. *(12-week)* Placement of son or daughter with you for adoption or foster care. [5 CFR 630.1203a(2)]

c. *(12-week)* Care of your spouse, son, daughter, or parent who has a serious health condition. [5 CFR 630.1203a(3)]

d. *(12-week)* A personal serious health condition which prohibits you from performing the essential functions of your position. [5 CFR 630.1203a(4)]

e. *(12-week)* Any qualifying exigency *(emergency)* arising out of the fact that the employee's spouse, son, daughter, or parent is on covered active duty in the Armed Forces, or has been notified of an impending call or order to covered active duty in the Armed Forces. [5 CFR 630.1203a (5)]

f. *(26-week)* Care for a servicemember with a serious injury or illness incurred in the line of duty. [Sec 585(b) of NDAA, 2008]

9. Are you currently using FMLA for any other purpose <input type="checkbox"/> Yes, I have another active FMLA request <input type="checkbox"/> No, this is my only request	10. Anticipated starting date	11. Anticipated ending date
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12. How many hours of each type of leave do you anticipate using for this request

a. Hours of leave without pay <i>(LWOP)</i>	b. Hours of sick leave <i>(if applicable)</i>	c. Hours of annual leave <i>(if applicable)</i>
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13. If request is for medical condition (option 8c or 8d), did you include the necessary medical certification <input type="checkbox"/> Yes <input type="checkbox"/> No	14. If request if for military family FMLA (option 8f), did you include a Form WH-385 <i>(or other complete certification)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
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15. Additional information relevant to your application *(if applicable)*

16. Employee's signature	17. Date submitted
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Approval *(section completed by manager)*

18. Manager's name	19. Title	20. Date
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21. Approved Disapproved

22. Provisionally approved pending medical certification

23. Reason for disapproval:

a. No entitlement *(e.g., doesn't meet the definition of family member or doesn't meet criteria to qualify for FMLA)*

b. Entitlement used for current 12-month period

c. Unacceptable medical certification *(if you selected 8c, d, or f above)*

d. Missing or incomplete documentation supporting exigency or military family FMLA

24. Actual dates of FMLA

a. Beginning date	b. Ending date
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