

**CITY OF CLARKSVILLE
REQUEST FOR FAMILY AND MEDICAL LEAVE**

EMPLOYEE INFORMATION	
1. Name: Social Security:	2. Title: Department:
3. Reason for requesting leave: <ul style="list-style-type: none"> a. <input type="checkbox"/> Birth of a child b. <input type="checkbox"/> Active Duty Leave to employee whose spouse, child or parent is called to active duty c. <input type="checkbox"/> Placement of a son or daughter for adoption/foster care. d. <input type="checkbox"/> Care for child, spouse, parent, or legal dependent with a serious health condition (be sure to answer #4 and #5) e. <input type="checkbox"/> Serious health condition which makes me unable to perform the functions of my position f. <input type="checkbox"/> Caregiver Leave of up to 26 weeks for a spouse, child, parent or nearest blood relative to care for a recovering service member. 	
4. If 3c is checked, please indicate: <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Legal Dependent	
5. Name and Address of Family Member: _____ _____	
6. Effective Date of Leave Request:	7. Date of anticipated return to work:
8. Are you requesting leave on an intermittent or reduced work schedule? <input type="checkbox"/> Yes* <input type="checkbox"/> No <small>*If yes, please provide a certification from a health care provider justifying the necessity for intermittent leave. On a separate sheet give a schedule of when you anticipate you will be unavailable for work.</small>	
9. I understand that sick, vacation and sick leave transfer leave, and leave without pay will all count towards my 12 weeks of leave	
Employees seeking leave because of Reason 3c or 3d <u>must</u> have a health care provider complete the Certification of Health Care Provider Form and return it to their personnel office within 15 days, or as soon as practicable. Leave may be delayed until a completed form is provided. Employees seeking to return to work after a leave because of Reason 3d, <u>also</u> must complete the Return to Work Medical Certification Form form before they will be allowed to resume work. Employees may not be permitted to resume any position until a completed Return to Work Medical Certification Form is provided.	

EMPLOYEE AGREEMENT

If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired, or that I am needed to care for a covered relative because he/she has a serious health condition on the date that my leave expired. I understand that while on FMLA leave, I will contact the Personnel Officer of my agency after I have been on leave for 30 calendar days and at the end of each 30-day period afterwards.

Signed: _____ Date: _____

Employee's Name: _____

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TO BE COMPLETED/MAINTAINED BY HUMAN RESOURCES

Employees on leave must contact the Human Resources Office of their agency after having been on leave for 30 calendar days and at the end of each 30-day period afterwards regarding their status and intention to return to work. This portion of the form is to be used by the Human Resources Office to keep track of the periodic reports by the employee.

SCHEDULE OF EMPLOYEE PERIODIC REPORTS DURING LEAVE

DATE OF PERIODIC REPORT	STATUS OF HEALTH CONDITION	DATE OF ANTICIPATED RETURN TO WORK	PERIODIC REPORT CONDUCTED BY

REMARKS:
