

FMLA Leave Request

Overview of FMLA		
<p>FMLA entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. Eligible employees are entitled up to 12 work weeks, or 26 work weeks, of leave in a 12-month period for:</p> <ul style="list-style-type: none"> - the birth of, adoption, or placement of a child in foster care to care for the child within one year - to care for the employee's spouse, child, or parent who has a serious health condition - a serious health condition that makes the employee unable to perform the essential functions of his or her job - qualifying exigency or to care for a covered service member with a serious injury or illness if the eligible employee is the service member's spouse, son, daughter, parent, or next of kin 		
Reason for Request		
<p>Please indicate your reason for applying for FMLA.</p> <p><input type="checkbox"/> Personal medical need</p> <p><input type="checkbox"/> Family medical need</p> <p><input type="checkbox"/> Birth of a child/ Adoption</p> <p><input type="checkbox"/> Military exigency need</p> <p><input type="checkbox"/> Service member medical need</p> <p><input type="checkbox"/> Personal/family member medical need requiring intermittent leave</p> <p><input type="checkbox"/> Workers' Comp</p>		
Leave Donation		
<p>Available leave will run concurrently with your FMLA. If your leave is exhausted while you are out on approved FMLA, then you have the option to request leave donations. Please elect an option below.</p> <p><input type="checkbox"/> I will request my department head to solicit leave donations on my behalf</p> <p><input type="checkbox"/> I will not request leave donations</p>		
Medical Coverage		
<p>If you are low on leave or may run out during your absence, you will need to complete Leave Without Pay (LWOP) paperwork. At this point you will not receive a paycheck and not be paying benefit premiums. To continue coverage you must set up a payment plan with the Benefits Division until you return back to work. Please elect an option below.</p> <p><input type="checkbox"/> I elect to keep my group insurance coverage while on LWOP. (I must set up a payment plan with Benefits)</p> <p><input type="checkbox"/> I do not want to keep my group insurance coverage. (I understand that I cannot re-enroll until the next Open Enrollment period. Please note: (Open Enrollment restrictions are not applicable to military leave))</p>		
Section to be completed by the employee requesting leave		
Printed Name	Signature	
Employee ID Number	Department Number/Name	
Phone Number	Date	
<p>I request the Family & Medical Leave benefit beginning _____ through _____.</p> <p style="text-align: center;">(First date unable to work) (Leave blank if unknown)</p>		
Acknowledgement of FMLA Request: Section to be completed by Supervisor and Director		
Supervisor Printed Name	Supervisor Signature	Date
Director Printed Name	Director Signature	Date
Authorization: Section to be completed by Benefits Administrator for approval		
<p><input type="checkbox"/> The request falls within City policy guidelines and has been approved</p> <p><input type="checkbox"/> The request does not fall within City policy guidelines and has been denied</p>		
Benefits Administrator /HR Designee Printed Name	Benefits Administrator /HR Designee Signature	Date

After Supervisor and Director signatures are obtained, please fax, email, or mail your signed FMLA Request form to Sarah Hanson in the Human Resources Department. **Fax:** 912.525.1528 **Email:** SHanson01@savannahga.gov
Mailing Address: PO BOX 1027, Savannah, GA 31402 **Office Phone:** 912-651-6545