FMLA Leave Request

SAVANNAH Human Resources Department

Overview of FMLA

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:

- 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

Please indicate your reason for applying for FMLA.

_____ Personal medical need
_____ Family medical need
_____ Birth of a child/ Adoption
_____ Military exigency need
_____ Service member medical need
_____ Personal/family member medical need requiring intermittent leave
_____ Workers' Comp

Leave Donation

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.

_____ I will request my department head to solicit leave donations on my behalf
_____ I will not request leave donations

Medical Coverage

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.

_____ I elect to keep my group insurance coverage while on LWOP. (I must set up a payment plan with Benefits)
_____ 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)

Section to be completed by the employee requesting leave

Printed Name	Signature
Employee ID Number	Department Number/Name
Phone Number	Date

I request the Family & Medical Leave benefit beginning _____ through _____.
(First date unable to work) (Leave blank if unknown)

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

_____ The request falls within City policy guidelines and has been **approved**
_____ The request does not fall within City policy guidelines and has been **denied**

Benefits Administrator /HR Designee Printed Name	Benefits Administrator /HR Designee Signature	Date

After supervisor and director signatures are obtained, the employee fax, mail, or hand deliver your signed FMLA Request form to Angelica Alfonso, Human Resource Analyst - Benefits Division - Human Resources Department

Fax: 912.525.1561 **Mailing Address:** PO BOX 1027, Savannah, GA 31402 **Address:** 5515 Abercorn St. Savannah, GA 31405

(Revised 03/2022)