REQUEST FOR FAMILY & MEDICAL LEAVE (FMLA)

EMPLOYEE INFORMATION (Please Print)		
Name (Last, First, MI)	**Personal (Home) E-mail Address**	**Employee ID #**
Home Mailing Address (Street/PO Box, City, State, Zip Code)		**Personal Phone**
Job Title/Department	**Name of Supervisor**	

PLEASE SELECT REASON(S) FOR YOUR LEAVE REQUEST (Additional documentation may be required to support request)

☐ The birth and care of my newborn child (Expected delivery date: ____/____/____).

☐ Adoption or the placement of a foster child in my home (Scheduled date of adoption or placement: ____/____/____).

☐ To care for my ☐Spouse ☐Parent or ☐Child (Age: _____)* who has a serious health condition.

☐ My own serious health condition (Work-related: ☐Yes ☐No).

☐ A qualifying exigency arising out of the fact that my ☐Spouse ☐Parent or ☐Child is a military member on covered active duty, or has been called to covered active duty status (or has been notified of an impending call or order to covered active duty).

☐ To care for my ☐Spouse ☐Parent ☐Child or ☐Next of Kin who is a covered servicemember or veteran recovering from a serious injury or illness incurred in the line of duty on active duty in the Armed Forces, or that existed before the beginning of his or her active duty and was aggravated by or that manifested itself before or after he or she became a veteran.

***Please note: In order to take FMLA leave to care for a child over the age of 18, the child must be "incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence."**

DATES OF LEAVE REQUESTED

☐ **Full-Time Leave**: I am requesting full-time leave from ____/____/____ through ____/____/____.

☐ **Reduced Leave Schedule**: I am requesting to reduce my work schedule from ____ hours per day/week to ____ hours per day/week beginning ____/____/____ through ____/____/____.

☐ **Intermittent Leave:** I am requesting an intermittent work schedule from ____/____/____ through ____/____/____.

☐ I have taken FMLA-protected leave previously: ☐Yes (____/____/____ to ____/____/____) ☐No

CONTINUATION OF BENEFITS

Employees on leave under the FMLA continue to receive the same level of employer-paid health care benefits under the same conditions as if the employee had continued to work. During paid leave (when an employee uses their leave accruals to remain out on leave and in pay status), the College will continue to make payroll deductions for the employee's share of the health care premiums. During unpaid leave (when an employee has exhausted all paid leave accruals), the employee must continue to make these payments while out on FMLA-protected leave. **Note: The employer's obligation to maintain health insurance coverage ceases under the FMLA if an employee's premium payment is more than 60 days late. If this occurs, insurance coverage will end as of the last day of the month for which a full premium was paid.**

If it is necessary for me to take all or a portion of my leave on an unpaid basis (leave without pay), I will pay the Human Resources Office for my share of health care premiums during my FMLA absence in the following way (e.g., personal check, money order): _____.

EMPLOYEE SIGNATURE

FMLA guidelines permit an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA due to your own serious health condition or to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections.

For employee requested leave, I understand that if my request for leave is incomplete or insufficient, CBC may not approve the leave. For employer designated (non-employee requested) leave, where the College determines the leave is FMLA qualifying and designates it as such, I understand I am still responsible for completion of forms. If I refuse to provide this information on a timely basis, I understand that CBC can evaluate the need for disciplinary action for insubordination.

I also understand and release appropriate personnel from the Human Resources Office (e.g. official Human Resources personnel only – not supervisors or department management) to contact my Health Care Provider to authenticate (confirm signature) or clarify information provided (illegible handwriting or meaning of response). If I refuse to provide this release, I understand that CBC can deny my request for leave.

Employee Signature	**Date**

RETURN COMPLETED FORM TO CBC HUMAN RESOURCES OFFICE
2600 N. 20TH AVE. (MS-A2), PASCO, WA 99301 | FAX: (509) 544-2029 | PHONE: (509) 544-4927