Application for Family Medical Leave

Name_____ _____ Date _____

Supervisor _____ _____ Department _____ _____

I wish to use Family Medical Leave (FMLA) leave for the following eligible purpose from _____ through _____ up to a maximum of twelve (12) weeks per rolling twelve (12) month period. Check appropriate box(es).

- ☐ Birth of a child, due _____
- ☐ Adoption of child, arriving _____
- ☐ Placement of child in foster care, beginning _____
- ☐ Seriously ill child, spouse or parent (medical verification required)
- ☐ Personal illness (medical verification required)
- ☐ Qualifying Exigency – active duty or call to duty status for military
- ☐ I need intermittent leave as indicated by my physician

I understand that I will be required to use any accrued sick, vacation, or comp. time concurrently with my FMLA leave. If sufficient paid leave is not available to cover the time requested, then unpaid leave of absence will be utilized up to the maximum 12 weeks. During any unpaid leave of absence, I will not accrue seniority, sick or vacation leave or retirement credit. I further understand that for any paid leave, insurance premiums will be deducted as usual from my paycheck. If I am using unpaid leave, the following arrangements will be made with Human Resources to submit my portion of the premiums.

- ☐ I will submit my portion of the insurance premium no later than the last day of the month for the following month's coverage. Failure to submit payment may result in loss of insurance benefits.
- ☐ N/A – I have sufficient paid leave to continue insurance benefits.

I understand that FMLA leave will run concurrently with any short-term disability, long-term disability and worker's compensation leave. However, you will not be required to use your paid vacation, sick leave or compensatory time if you are on worker's compensation leave.

Any unpaid leave beyond the maximum 12 weeks must be requested in writing to your Department Manager and is subject to approval of the City Manager and may be granted for a maximum of thirty (30) days.

I understand that if I do not return to City service after the expiration of my Family Leave, I may be terminated. In addition, I may be required to repay the City of Lewiston for any City paid Health Insurance contributions made on my behalf during the unpaid period.

I understand that if I return to employment for the City of Lewiston, I will be restored to the same or similar position without loss of accrued benefits, compensation or other terms of employment before my leave. In the event that I do not return to employment on the specified return date, my termination will be processed as voluntary.

_____ _____

Signature Date

Medical Verification

Medical verification is required for Family Medical Leave and must be received by Human Resources within 15 calendar days of FMLA start date. A statement or document(s) from your health care provider which include the following:

- Medical facts supporting the need for leave;
- The probable duration of the condition;
- An estimate of the number of treatments
- A general description of the treatment
- A description of the need for leave to care for a family member

If leave is requested for a medical condition for you or a family member, you or that family member must submit a signed release of medical information to the City of Lewiston. A sample form is available on the City Website. (HR-Forms)

_____

To be completed by Human Resources

You currently have _____ hours of sick leave, _____ hours of vacation, and _____ hours of comp time accrued. FMLA leave runs concurrent with paid leave. Your current accrual ☐ will ☐ will not be adequate to cover the requested FMLA leave.

You ☐ are ☐ are not eligible for leave under the FMLA. Comments:

_____

_____

The requested leave ☐ will ☐ will not be counted against your annual FMLA leave entitlement. You have 12 weeks of FMLA leave available during the period _____ to _____. You have currently used _____ weeks of FMLA leave.

You ☐ will ☐ will not be required to present a "fitness to return to work" statement from your health care provider at least two (2) days prior to being restored to employment. ***Please forward your doctor's release to Human Resources.***

While on leave, you ☐ will ☐ will not be required to furnish us with periodic reports every 14 days of your status and intent to return to work.

_____ _____

Human Resources Date

Copy Forwarded to Department: _____

Enter FMLA absence on timecards Date

Copy to Finance: _____

Date

Copy Mailed to Applicant: _____

Date