



Cooperative Educational Service Agency No. 8
 PO Box 320
 Gillett, WI 54124-0320

Family or Medical Leave Act (FMLA) Request Form

This form must be completed and returned to the Human Resources Benefits Administrator when you request FMLA. Documentation supporting your situation must be attached to this form or provided within 15 days after your request.

- Name _____
- Date _____
- Department _____
- Title _____
- Hire Date (or date became a full time employee) _____
- Supervisor _____

I'm requesting a leave of absence from _____ to _____ for the reason checked below:

Medical Leave:

_____ Employee's serious health condition / pregnancy

Family Leave:

_____ Fathers' attendance at birth of a child

_____ Parents' care of child following birth

_____ Placement of a child with employee for adoption or foster care

_____ Serious health condition of an employee's child (under 18 years or disabled)

_____ Serious health condition of employees' spouse or parent

Is leave request for _____ a single block of time,
 _____ or intermittent/reduced work schedule?

Please provide an estimate of the time you will be away from work.

I understand that a failure to return to work at the end of my approved leave period, if 12 weeks or less, may be treated as a resignation unless an extension has been agreed upon and approved by Human Resources. Also, I may be replaced in my current position if my absence exceeds 12 weeks, and later terminated if a suitable position cannot be found when I am released to return to work. Failure to provide medical evidence any time may be considered grounds for termination.

 Signature

 Date

 Address (this address should be where you can be reached while on leave)

 Address (cont.)

 Telephone Number