Family and Medical Leave Request Form
(Family and Medical Leave Act)

State of Nebraska

Employee Name: _____

Agency: _____

1. I have at least twelve months service with the State of Nebraska. **YES** **NO**
Note: *Service may be with more than one Agency -- service need not be continuous.*

2. I have been paid for at least 1,250 hours of work by the State of Nebraska in the past twelve months. (Does not include leave hours) **YES** **NO**

Go forward only if all previous Questions have been answered YES and you have not used more than twelve weeks of FMLA Leave in the past twelve months.

3. Reason for FMLA Leave:

Note: *FMLA Leave under the following circumstances must be completed no later than one year after the child's birth, adoption, or foster care placement.*

☐ I am the mother or father of a newborn child. The child's birthdate or expected birthdate is _____.

☐ I am adopting or have legally adopted a child. The date of child's placement in my home was/is _____.

☐ Placement of a foster child in my home. The date of child's placement in my home was/is _____.

☐ Personal request due to exigencies arising out of the fact my spouse, son, daughter, or parent is on active duty or call to active duty status as a member of the National Guard, Reserves, or regular duty Armed Forces personnel who are deployed to a foreign country, in support of a contingency operation.

Note: *In each case below, a serious health condition is defined as requiring one of the following: (1) inpatient care, (i.e. an overnight stay); (2) a period of incapacity of more than three consecutive calendar days, and treatment two or more times by a health care provider, or treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider; (3) incapacity due to pregnancy or prenatal condition (4) a chronic condition requiring at least two visits per year for treatment by a health care provider; or (5) a permanent/long-term condition requiring supervision* *This does not include voluntary or cosmetic treatments unless inpatient hospital care is required.*

Note: *In each case below, a* ***Health Care Provider's Certification Form*** *must be completed and returned within 15 calendar days of submission of this form.*

☐ Care for my seriously ill mother or father. *(if not your biological or adoptive parent, you must present satisfactory evidence of parental relationship -- care for a mother-in-law or father-in-law does not qualify for FMLA Leave)*

☐ Care for my seriously ill spouse. *(must be legal spouse; unmarried domestic partners do not qualify for FMLA Leave)*

☐ Care for my seriously ill child. *(If not your biological, adoptive, foster, or step-child, you must present documentation of parent-child relationship)*

☐ Personal request due to my serious health condition or injury *(would include recovery from childbirth or extended pre-natal care).*

Note: *In the cases below, a* ***Serious Injury or Illness of a Current Service Member Certification Form*** *or* ***a Serious Injury or Illness of a Veteran for Military Caregiver Leave Certification Form*** *must be completed and returned within 15 calendar days of submission of this form.*

☐ I am the next of kin of a current service member who has a serious illness or injury incurred in the line of duty, while on active duty.
☐ I am the next of kin of a Veteran who has a serious illness or injury that was incurred or aggravated when the covered veteran was a member of the Armed Forces.

4. I understand that FMLA Leave is strictly unpaid leave that is used at the employee's discretion for qualifying events. Accrued paid leave may be used as part of the 12 weeks, under the conditions noted previously, at the employee's discretion.

5. I understand that in cases where FMLA Leave is foreseeable, I must apply, for FMLA Leave a minimum of 30 days in advance. In cases where FMLA Leave is not foreseeable, I understand it is my responsibility to apply for FMLA Leave as early as possible and practicable, either before or after the FMLA Leave event.

Note: *In all circumstances, employees are required to complete this form.*

6. My first day of absence from work will be _____, and I will return to work on _____. If exact dates are unknown, please enter approximate dates.

Note: *Total absence may not exceed twelve weeks or twenty-six weeks for service member caregiver leave. In cases of childbirth, adoption, or foster child placement, the employer may require the leave to be taken in a single continuous period. In cases of serious health condition, leave may be taken intermittently for medical reasons, according to a schedule approved by the health care provider (attach leave schedule to the Health Care Provider's Certification Form).*

7. I understand that FMLA Leave is strictly unpaid leave. Requests for sick and vacation leave and/or compensatory time will be processed according to applicable labor contracts or Personnel Rules. Use of sick leave, vacation leave and compensatory time **may** be counted towards my twelve weeks of FMLA Leave.

8. I understand that sick and vacation leave will not accrue and holidays will not be compensated during non-paid absences.

9. I understand that my service date will be adjusted if my unpaid absence exceeds fourteen consecutive calendar days.

10. I understand that I must complete the ***Insurance Coverage Continuation Form***.

11. I understand that if the absence from work was due to my personal health condition, I must submit a "Release for Duty" report from my Health Care Provider prior to my return to work.

12. I understand that when I return to work, I will be returned to the same job I left or an equivalent job and that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing.

Employee Signature: _____ Date: _____

☐ ***Approved***

☐ ***Denied*** (employee requests may not be denied without prior notification to AS-Employee Relations Division)

Agency Authorized Signature: _____ Date: _____

If you need help using this form, please contact your agency Personnel Office or AS Employee Relations at (402) 471-8292 - TDD (402) 471-4693