

Sample FMLA Request Forms

Sample FMLA Request Form #1 – 1 Block of Time

Sample FMLA Request Form #2 – Intermittent Leave

Sample FMLA Request Form #3 – Reduced Schedule

Sample FMLA Request Form #1 – 1 Block of Time

TO: [Name of Director of Human Resources, Supervisor, or Other Manager]

FROM: [Your name, Job Title]

RE: Notice of the Need for **FMLA** Leave

Date: [Today's Date]

This memo is to notify you of my need for leave under the Family and Medical Leave Act. I require a leave of absence from [Start Date] to [End Date].
because:

 I am temporarily unable to work because of my own serious health condition.

 I will be caring for a family member (spouse, child, or parent) with a serious health condition.

I have attached a completed certification from a health care provider documenting my need for leave.*

It is my understanding that I am eligible for up to 12 weeks of leave per year under the Family Medical leave Act and that I will be reinstated to my job after my leave. *[If you are covered by your employer's health insurance include this sentence, It is also my understanding that (Employer's Name) will continue my health insurance during my leave.]*

The Family and Medical Leave Act specifies that employers must provide specific written notice to an employee of rights and responsibilities regarding leave within a few business days of when that employee gives notice of the need for leave (29 C.F.R. 825.301). I look forward to receiving this information from you.

Please let me know immediately and in writing if you require anything further from me. I appreciate your assistance with this matter.

* Although medical certification is not required unless your employer asks for it, to protect your rights fully, include this sentence and attach the certification. You do not need to disclose a diagnosis to certify your need to take leave. To access the FMLA Medical Certification form WH-380 go to:

www.dol.gov/esa/regs/compliance/whd/fmla/wh380.pdf

Sample FMLA Request Form #2 – Intermittent Leave

TO: [Name of Director of Human Resources, Supervisor, or Other Manager]

FROM: [Your name, Job Title]

RE: Notice of the Need for **FMLA** Leave

Date: [Today's Date]

This memo is to notify you of my need for intermittent leave under the Family and Medical Leave Act. I require intermittent leave from [Start Date] to [End Date] . because of:

 temporary absences due to my own serious health condition.

 temporary absences due to caring for a family member (spouse, child, or parent) with a serious health condition.

I have attached a completed certification from a health care provider documenting my need for leave. *

It is my understanding that I am eligible for up to 12 weeks of leave per year under the Family Medical leave Act and that I will be reinstated to my job after my leave. It is also my understanding that when a health care provider certifies a need for intermittent FMLA leave for a period exceeding 30 days, an employer may not require additional certifications during that period unless a request is made to extend the leave, circumstances change significantly, or the employer receives information that casts doubt on the need for leave. (See 29 C.F.R. 825.308(b)(2)).

The Family and Medical Leave Act specifies that employers must provide specific written notice to an employee of rights and responsibilities regarding leave within a few business days of when that employee gives notice of the need for leave (29 C.F.R. 825.301). I look forward to receiving this information from you.

Please let me know immediately and in writing if you require anything further from me. I appreciate your assistance with this matter.

* Although medical certification is not required unless your employer asks for it, to protect your rights fully, include this sentence and attach the certification. You do not need to disclose a diagnosis to certify your need to take leave. To access the FMLA Medical Certification form WH-380 go to:
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Sample FMLA Request Form #3 – Reduced Schedule

TO: [Name of Director of Human Resources, Supervisor, or Other Manager]

FROM: [Your name, Job Title]

RE: Notice of the Need for **FMLA** Leave

Date: [Today's Date]

This memo is to notify you of my need for a reduced schedule under the Family and Medical Leave Act. It is medically necessary to change my schedule to_____. because of:

_____my own serious health condition.

_____caring for a family member (spouse, child, or parent) with a serious health condition.

I have attached a completed certification from a health care provider documenting my need for leave.*

It is my understanding that I am eligible for up to 12 weeks of leave per year under the Family Medical leave Act and that I will be reinstated to my job after my leave. [*If you are covered by your employer's health insurance include this sentence, It is also my understanding that (Employer's Name) will continue my health insurance during my leave.*]

The Family and Medical Leave Act specifies that employers must provide specific written notice to an employee of rights and responsibilities regarding leave within a few business days of when that employee gives notice of the need for leave (29 C.F.R. 825.301). I look forward to receiving this information from you.

Please let me know immediately and in writing if you require anything further from me. I appreciate your assistance with this matter.

* Although medical certification is not required unless your employer asks for it, to protect your rights fully, include this sentence and attach the certification. You do not need to disclose a diagnosis to certify your need to take leave. To access the FMLA Medical Certification form WH-380 go to:

www.dol.gov/esa/regs/compliance/whd/fmla/wh380.pdf

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