CITY OF HENDERSONVILLE
FAMILY AND MEDICAL LEAVE REQUEST FORM

Employee Name:	**Home Telephone Number:**
Current Mailing Address:	
Department:	

Reason for Leave:

- ☐ Birth of my child and/or to care for the new born child
- ☐ Placement of a child with me for adoption or foster care
- ☐ To care for a family member with a serious health condition (medical certification required)
- ☐ My own serious health condition (medical certification required)
- ☐ Military exigency

Briefly explain reason for leave request (If leave is to care for a family member, please specify your relationship to the family member):

ANTICIPATED DATES OF LEAVE:

From: _____ Through:_____
(Date) (Date)

I am requesting leave on an intermittent or reduced leave schedule. ☐ Yes ☐ No
I anticipate that I will need the leave on the following schedule or basis:

The City of Hendersonville's policy requires an employee to exhaust all leave in the following order (1) compensatory, (2) sick and (3) vacation leave prior to going on leave without pay.

I understand that I will be required to furnish medical certification of a serious health condition and/or a family member. I further understand that this certification must be submitted to the Human Resources Department within 15 days. I authorize the City of Hendersonville Human Resources Department to obtain clarifying information from the health care provider regarding my request for family and medical leave.

Employee Signature:	**Date:**

If your leave is approved, you will receive a letter from Human Resources detailing the City's policy and your rights under FMLA. Please feel welcome to address any questions concerning FMLA with Human Resources. You may contact Human Resources at 697-3003.

Department Head Signature:	**Date Received:**

Department Head should *immediately* forward request form to the Human Resources Department.

Human Resources Department:

Date Request Received:	Medical Certification Received:
Employee has worked ☐ at least 12 months for City of Hendersonville. ☐ at least 1,250 hours in the 12-month period immediately preceding the start of the leave	
Employee is ☐ eligible ☐ not eligible for FMLA	Condition ☐ qualifies ☐ does not qualify for FMLA
FMLA ☐ approved ☐ denied Effective date of FMLA:	Signature of HRD Representative: