THE CITY OF AKRON
REQUEST FOR FAMILY AND MEDICAL LEAVE

A request for FMLA leave must be made at least 30-days prior to the date on which the requested leave is to commence, or as soon as practicable which is generally not later than one or two days after the need for leave is known. To be eligible for leave, you are required to have been employed for at least twelve (12) months within the last seven (7) years **and** worked one thousand two hundred fifty (1,250) hours during the twelve (12) months immediately prior to the start date of the leave. For additional information, please refer to the City of Akron's Family and Medical Leave Policy.

Form to be completed by employee.

Employee Name: _____ **ID Number:** _____

Address: _____ _____ _____
Street/Box City Zip Code

Contact Phone Number: _____ **Work Phone:** _____

Division: _____ **Position:** _____

Hire Date: _____ **Scheduled #Days/Week:**_____ **Scheduled #Hours/Week:** _____

I REQUEST FAMILY/MEDICAL LEAVE FOR THE FOLLOWING REASON:

☐ The birth of a son or daughter and to care for the newborn child, expected delivery date _____.

☐ The placement of a child with me for adoption or foster care, date of adoption/placement _____.

☐ My own serious health condition that makes me unable to perform the essential functions of my job.

☐ Due to a serious health condition, I am needed to care for my: ☐ spouse ☐ parent ☐ son or daughter

Name of Family Member: _____ If son or daughter, list age when leave is to start: _____

☐ A qualifying exigency arising out of the fact that my spouse, son, daughter, or parent is a covered military member on active duty or has been notified of an impending call or order to covered active duty status.

☐ To care for a covered servicemember who is your spouse, son, daughter, parent, or next of kin with a serious injury or illness.

Name of Family Member: _____ Relationship: _____

I AM REQUESTING: ☐ Continuous Leave Start Date: _____

☐ Intermittent* ☐Reduced Schedule Leave* End Date: _____

***Explain the medical need and schedule for intermittent or reduced schedule leave and why such medical need can best be accommodated through an intermittent or reduced schedule leave schedule**:

CERTIFICATION: I certify that the leave/absence(s) requested above is for the purpose indicated. I understand that falsification or submission of fraudulent information shall be grounds for discharge.

Employee's Signature:_____ **Today's Date:**_____

Manager's Signature:_____ **ID Number:**_____ **Date:**_____

Your signature indicates that you have received the "Request" for FMLA leave. ***You must send this form to the Employee Benefits Division IMMEDIATELY for further processing and approval.***

Revised 1/09, 9/14